

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may

be filled in by the funeral director, page 5 may

be filled in by the attending physician. After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign below.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08279	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 3/29/87									2b. HOUR 1326 M	
1. DECEASED NAME (TYPE OR PRINT) ANDREW WILLIAM ALTMAN			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 12 30 08			6. AGE (IN YEARS LAST BIRTHDAY) 78 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.				
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial			12a. USUAL OCCUPATION Farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture				
13a. STATE Maryland			13b. COUNTY Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 11804 Woodsboro Pike/ 21757				
14. FATHER'S NAME FIRST George MIDDLE P. LAST Altman			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Wachter										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-36-6655			17. INFORMANT Mrs. Lula W. Altman, Keymar, Maryland 21757							
18. CAUSE OF DEATH (Enter only one cause per line for Part I, and up to three causes for Part II.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) cerebral anoxia 2° out of hospital													
DUE TO, OR AS A CONSEQUENCE OF (c) cardiac arrest 2° myocardial infarction													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (his) hospital attended the deceased from 3/29/87 to 3/29/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.													
22b. SIGNATURE John A. Vitarello MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/29/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. VITARELLO MD			22e. ADDRESS 335 Park Avenue, Frederick, Md. 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 1, 1987			23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery			23d. LOCATION Frederick, Frederick, Md.				
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR APR 02 1987			25b. REGISTRAR'S SIGNATURE John J. Vitarello							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 4 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1A-3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 1 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A-2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF NATURAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 0 8 2 8 0			
1- STATE REGISTRAR		Item #16b, Film #G626 4/24/87 sjb															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR			
John G.						Ball, M.D.		<input checked="" type="checkbox"/>		3		19		1987			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY	
Male		White		MONTH DAY YEAR Oct. 2, 1908		78 yrs.		MONTHS DAYS		HOURS MIN.		3 19 1987		5:26 p.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.												Frederick County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Memorial Hospital										Physician		Medical Physician			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/>		7041 Catalpa Rd., 21701									
14. FATHER'S NAME		FIRST Michael		MIDDLE Valentine		LAST Ball		15. MOTHER'S MAIDEN NAME									
								FIRST Grace		LAST Patterson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT									
Yes		W. W. II		214-42-2132 3132		7041 Catalpa Rd., Frederick, Md. 21701		Michael S. Ball, Frederick, Md. 21701									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  8121      IMMEDIATE CAUSE (a) <u>Multiple injuries</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)  DUE TO, OR AS A CONSEQUENCE OF																	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input type="checkbox"/> AM. MONTH DAY YEAR 4:45 M. 3 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET Rts 80 & 340		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant										DATE SIGNED 3/20/87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St. Balto. MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
Cremation		Mar 21, 1987		Smithsburg Crematory		Smithsburg		Washington		Md.							
24. FUNERAL DIRECTOR SMITH, Keehey and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
		MAR 26 1987		Julia Davidson-Landree													

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MAK 10 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-tranport permit. This page should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 either only injury, or only traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

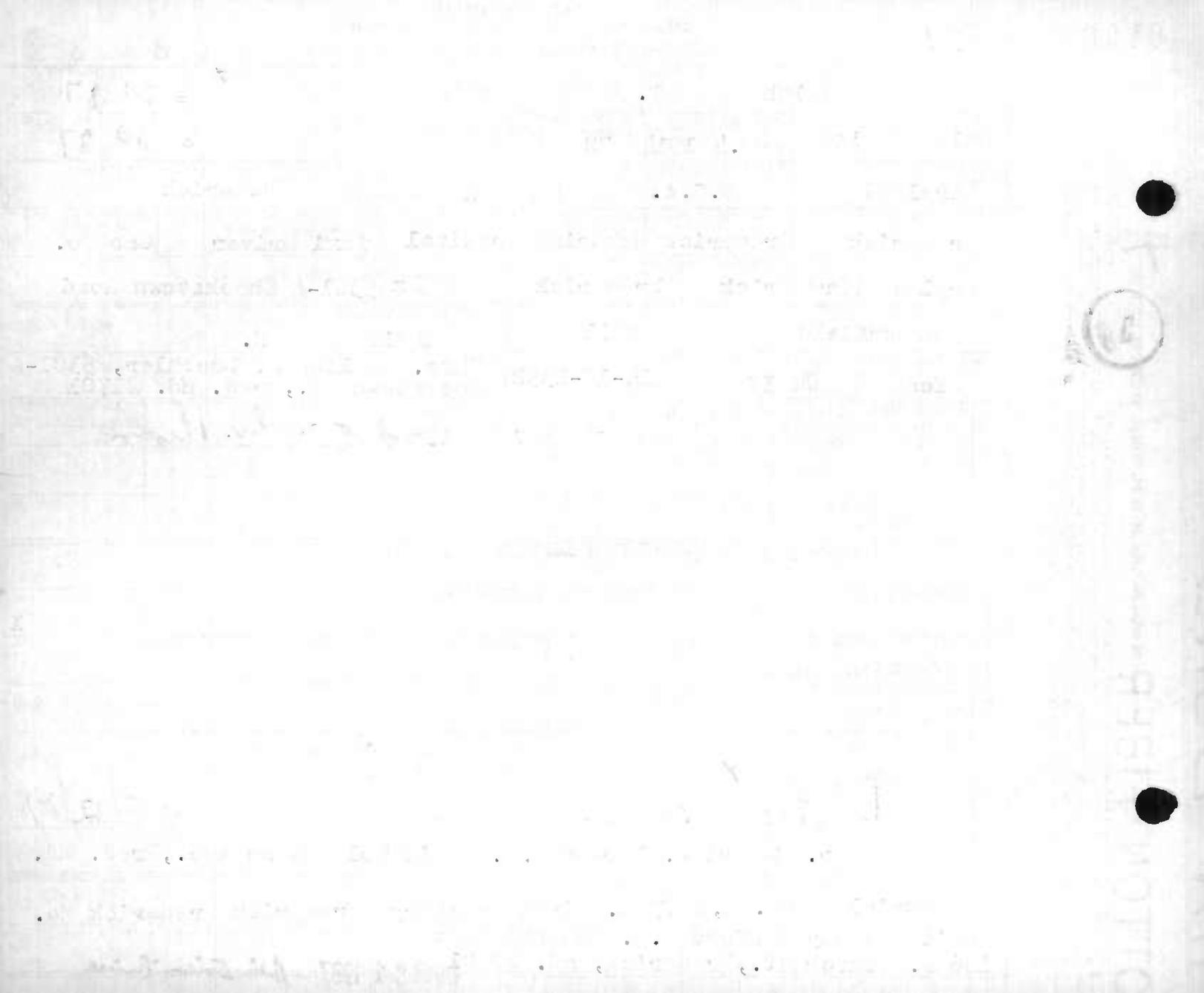
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8708281				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
June Louise Baumgardner						3 - 26 - 87						2255 M		
3. SEX			4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Fe			CAVL		MAY 5 1938		47			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			FREDERICK CO MD				
MD			USA											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			LOOM SUPPORT SUPPLY			
FREDERICK FREDERICK HOSP					EDNA TANEYTON			21787			21787			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
CARROLL TANEYTON			MD		CARROLL		TANEYTON		NO		5134 BOHERS RD.			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	GIGGARD		
ALBERT					DELL	EDNA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
NO			212-38-1399		BAUMGARDNER			RICHARD			5134 BOHERS RD.			
PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Reportic</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Exercise small cell</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									2 mo					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cancer of lung</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1986</i> to <i>4/26 1987</i> , that (we) last saw the deceased alive on <i>4/26 1987</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.														
22b. SIGNATURE <i>P. J. RAUSCH</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/27/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. J. RAUSCH</i>			22e. ADDRESS 2101 FREDERICK, MD 21787 FREDERICK MEMORIAL			22f. DATE REC'D. BY REGISTRAR <i>1234</i>			22g. REGISTRAR'S SIGNATURE <i>Julia Jackson-Randall</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>3/30/87</i>			23c. NAME OF CEMETERY OR CREMATORIAL BRETHREE CEM. & CARLSON			23d. LOCATION CITY OR TOWN TANEYTON			COUNTY	STATE	
24. FUNERAL DIRECTOR <i>Ruby Little</i>			24b. ADDRESS <i>34 May Ave</i>			24c. DATE REC'D. BY REGISTRAR <i>APR 06 1987</i>			24d. REGISTRAR'S SIGNATURE					

4/14

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1c, 2c, 3c, 5c, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 5 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08282	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR	
Ralph			T.		BELL	<input type="checkbox"/> 3 20 87							
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male		White	Aug. 4 1914	72			3 20 87						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital			Taxi Driver			Cab Co.					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21701			
Maryland		Frederick	Frederick				5301-A Shookstown Road						
14. FATHER'S NAME		FIRST	MIDDLE	BELL	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Summerfield					Effie					M.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes		WW II			214-10-2352			Mrs. Pauline E. Loechler, 5301-A Shookstown Rd., Fred. Md. 21701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asterotocleric Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED	
ACTUAL SIGNATURE <i>Robert J. Thomas M.D.</i>		TITLE (SPECIFY) Deputy M.D.			MEDICAL EXAMINER			3/22/87					
EXAMINER'S NAME (TYPE OR PRINT)		Dr. Robert J. Thomas M.D.			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial		Mar. 24, 1987			Mt. Olivet Cemetery			Frederick			Frederick	Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John Keeney Basford P.A. Funeral Home		106 E. Church St., Frederick, Md. 21701			MAR 31 1987			<i>John Keeney</i>					
BP													
DHMH - 17													
(VR A15 ME (5))													
20M 4/B2													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and attach pages 1 and 2 which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other terminal condition,

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8708283					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 03-11-87									2b. HOUR 1650 PM					
1. DECEASED NAME (FIRST OR PRINT) ANASTASIA Anastasia Nugent Bienfang			MIDDLE NUGENT			LAST BIENFANG			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 90 YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
3. SEX Female F			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1896			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin			8. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.		
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY None								
13a. STATE Illinois			13b. COUNTY Ogle			13c. CITY OR TOWN Rochelle			13d. INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 617½ N. 9th St. 161068 99999					
14. FATHER'S NAME John			MIDDLE G.			LAST Nugent			15. MOTHER'S MAIDEN NAME Louise			16. ADDRESS 617½ N. 9th Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 358-30-0611			17. INFORMANT Mr. F. John Bienfang						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Intracerebral hemorrhage 6 days			(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a None																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 3/5/87 to 3/11/87, that (I) (we) lost saw the deceased alive on 3/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 3/11/87					
22b. SIGNATURE M. Raphaelson			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 4 W 7th St Frederick MD								
22f. PHYSICIAN'S NAME (FIRST OR PRINT) M. Raphaelson																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-12-1987			23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg, Washington, Md. COUNTY STATE								
24. FUNERAL DIRECTOR R.E. DAILEY & SON, PA			24b. ADDRESS 1201 N. Market Street Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR MAR 13 1987			25b. REGISTRAR'S SIGNATURE John Davidson								

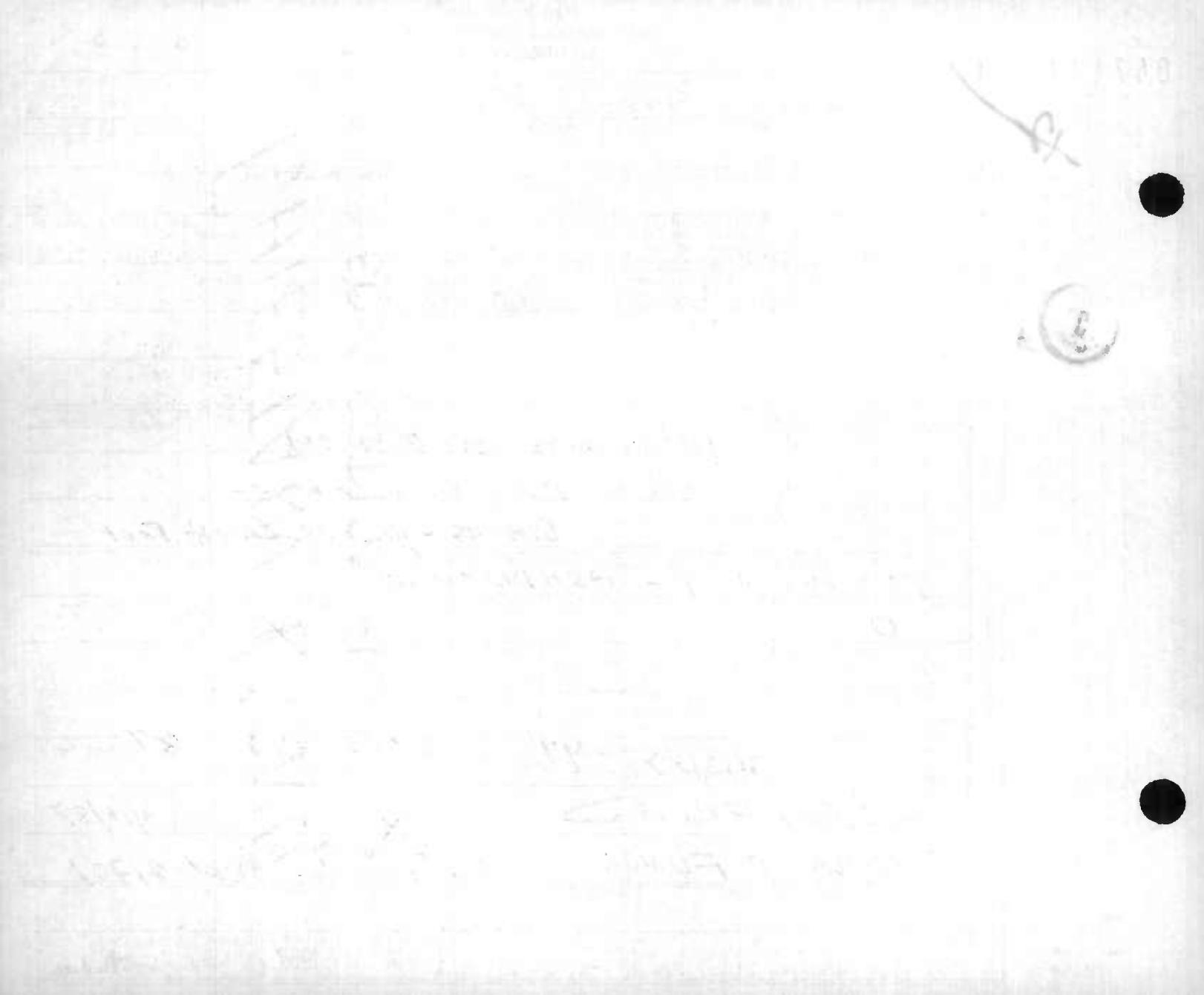
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8708284							
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR							
I. DECEASED NAME [TYPE OR PRINT]			FIRST MIDDLE LAST			03 13 1987									13:25 M				
STANLEY Eugene BLANK																			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
MALE			WHITE			02 07 1919			68			YEARS		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
MD			USA						FREDERICK										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION 1 TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY										
FREDERICK			FREDERICK MEMORIAL HOSPITAL						MASON			CONSTRUCTION							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)												21701							
13a. STATE MD		13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 8102 Edgewood Church Road,										
14. FATHER'S NAME FIRST HARVEY L. MIDDLE BLANK LAST			15. MOTHER'S MAIDEN NAME FIRST OLIVE MIDDLE M. LAST STUP			ADDRESS				Frederick, MD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>													
DOUE TO, OR AS A CONSEQUENCE OF {(b) <i>severe P.V. O. Dis. Both legs -</i>			DOUE TO, OR AS A CONSEQUENCE OF {(b) <i>severe P.V. O. Dis. Both legs -</i>			DOUE TO, OR AS A CONSEQUENCE OF {(c) <i>Diabetes - governule casts of foot</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>previous M.I. - ASH DISEASE.</i>																			
19a. DATE OF OPERATION 0			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NUMBER OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <i>3/13/87</i> , 1987, to <i>3/13</i> , 1987, that (I) (we) last saw the deceased alive on <i>3/13/87</i> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Nicholas P. Foris M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3/16/87</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NICHOLAS P. FORIS</i>			22e. ADDRESS <i>27 W. 7th St. Frederick - Mol 21701</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/16/87			23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens			23d. LOCATION CITY OR TOWN Frederick			23e. COUNTY Frederick				23f. STATE MD			
BURIAL																			
24. FUNERAL DIRECTOR NAME 1621 Opossumtown Pike, Frederick, MD 21701			G. DOUGLAS STAUFFER ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 17 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Darden-Randall</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon paper, page 1 and 2, and attach to the burial permit. This will be done by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 20 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8708285		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Doris Geraldine Booth						March 17, 1987						10:15 P		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Sept. 20, 1921			65			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Pa.		USA					Frederick County, MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Owner			Grocery Store					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland	Frederick	Frederick				1401A Key Parkway East / 21701								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Waitman		K.	McWilliams	Lillian			Viola		Painter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			235-20-1786			Robert O. Booth - Frederick, Md. 21701			1401A Key Parkway E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Metastatic Lung Cancer														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> the hospital attended the deceased from 3/17/87 to 3/17/87, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.														
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		JAMES S. GRISSEN			22e. ADDRESS			1475 TANEY Ave. Suite 204			3/17/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial		3/21/87		Mt. Olivet Cemetery			Frederick, Frederick, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John T. Williams Funeral Home		Brunswick, Md.			MAR 26 1987			John T. Williams						



999999 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 0 8 2 8 6

DECEASED NAME (TYPE OR PRINT)	FIRST <i>Joseph</i>	MIDDLE <i>Edmund</i>	LAST <i>Bowers</i>	2a. DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b. HOUR 7:30 AM	
1. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR 9 22 63		6. AGE (IN YEARS LAST BIRTHDAY) 23 XXXX YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b>		MD.	
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>WEST VA.</b>	13b. COUNTY <b>BERKELEY</b>	13c. CITY OR TOWN <b>KEARNEYSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Rt. 3 Box 675, 25430 99999</b>			
14. FATHER'S NAME FIRST <b>JOHN</b>	MIDDLE <b>ROBERT</b>	LAST <b>BOWERS</b>	15. MOTHER'S MAIDEN NAME FIRST <b>DOROTHY</b>	MIDDLE	LAST <b>GORMAN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>N/A</b>	16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>	17. INFORMANT <b>John R. Bowers II</b>		ADDRESS <b>Kearneysville, W.VA</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart disease</i>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute bronchitis</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION <i>NP</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) <i>this hospital</i> attended the deceased from <i>3/1/87</i> , to <i>3/31/87</i> , that (I) (we) last saw the deceased alive on <i>3/31/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Lloyd Halverson</i>	DEGREE			ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED <i>4/11/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lloyd Halverson</i>	22e. ADDRESS <i>1475 Taney Ave</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>4/3/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>LEWISTOWN CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>LEWISTOWN</b>	COUNTY <b>FREDERICK</b>	STATE <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>G. DOUGLAS STAUFFER</b> ADDRESS <b>1621 Opossumtown Pike, Frederick, MD 21701</b>	25a. DATE REC'D. BY REGISTRAR <b>APR - 2 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia S. Stauder</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If Item 21 is marked on Item 18, it must be marked on Item 18.

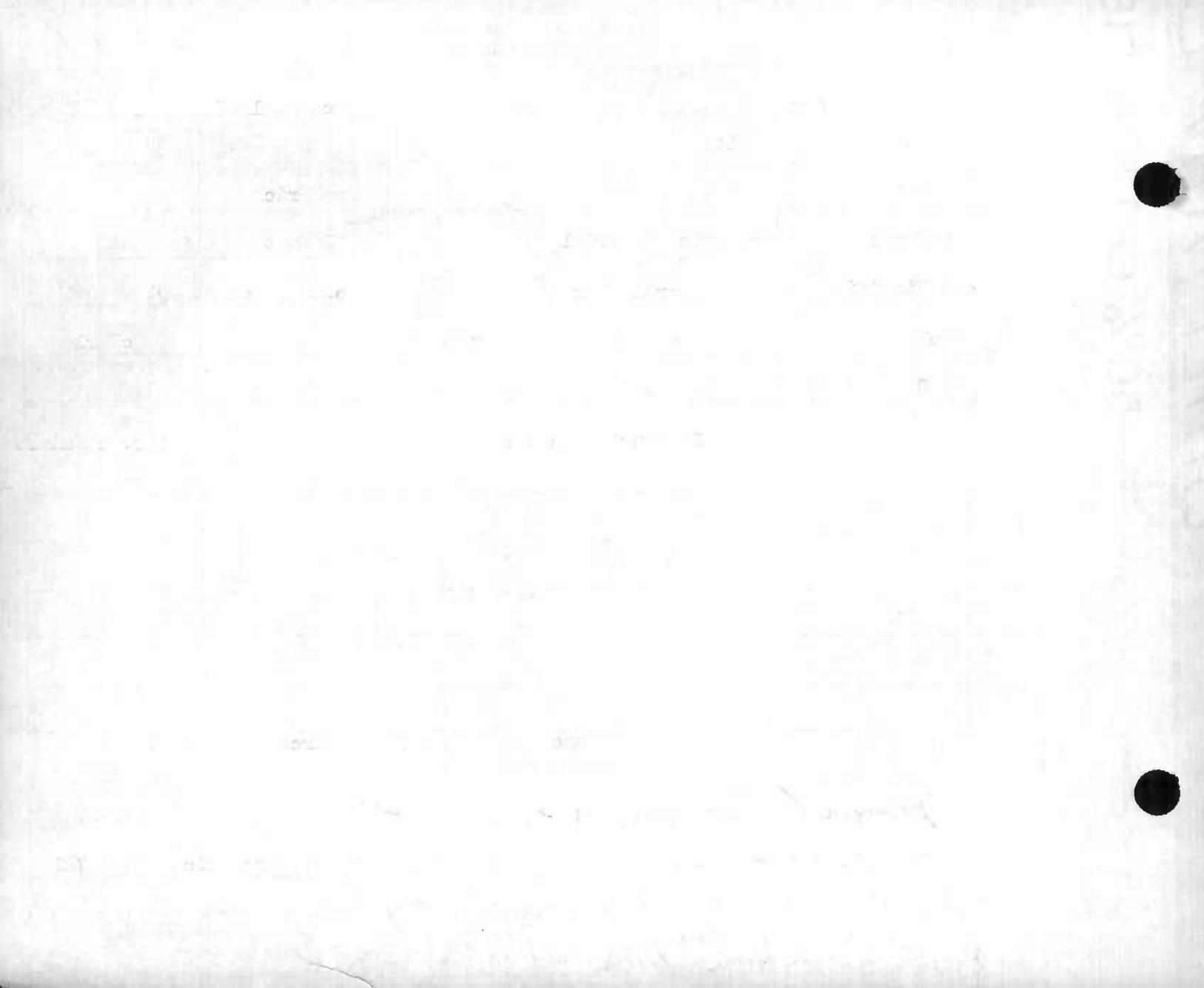
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

REG. NO.

08287

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Reuben						Breeden	March 2, 1987				1:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		MONTH	DAY	YEAR	0	0	YRS	MONTHS	DAYS	IF UNDER 24 HRS		
				3	2	87				1	29	MONTH HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		USA		MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial					Infant			NA				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
West Virginia		Berkeley		Martinsburg		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Route 2 Box 309-94			99999			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
Reuben			Breeden	Dawn						McFarland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
NO				None			Mr. & Mrs. Reuben Breedon Martinsburg, WV			Rt. 2, Box 309-94				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity, severe</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr. 29 mins.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 2, 1987, to March 2, 1987, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Wayne L. Crowder, M.D.</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-2-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne L. Crowder, M.D.		22e. ADDRESS 1475 Taney Avenue, Frederick, MD 21701												
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5 March 87			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Cemetery		23d. LOCATION Towling Waters Berkeley Co. Md.							
24. FUNERAL DIRECTOR NAME Charles Brown Brown Funeral Home		25a. DATE REC'D. BY REG. ST. / 25b. REG. ST. SIGNATURE MAR 12 1987												
DWHM 165DM 1/81 (VRA 15, 4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this to the death certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other condition, in addition to the terminal disease, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 0 8 2 8 8				
1 - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)				FIRST Hartwood	MIDDLE NMN	LAST Cornell Sr.	March 22, 1987								0806 A	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH 09 DAY 25 YEAR 1904				6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				
Male		White						82 YRS				MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD								
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner				12b KIND OF BUSINESS OR INDUSTRY Gasoline						
13a STATE MD		13b. COUNTY Frederick		13c. CITY OR TOWN Woodsboro		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 505 S. Main St., 21798								
14. FATHER'S NAME RICHARD		MIDDLE M.		LAST CORNELL		15. MOTHER'S MAIDEN NAME ANNA		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				17. INFORMANT ADDRESS Hartwood Cornell, Jr. 505 S. Main St., Woodsboro, MD 21798				
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN METASTASIS														
		DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHIOGENIC CARCINOMA														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LUNG ABSCESS																
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a I certify that (I) (this hospital) attended the deceased from September 19, 1970, to March 19, 1987, that (I) (we) last saw the deceased alive on March 21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE George I. Smith Jr.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED April 22, 1987										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 804 Tollhouse Ave., Frederick, MD														
GEORGE I. SMITH, JR.																
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/25/87		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens				23d LOCATION CITY OR TOWN Frederick								
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR APR - 2 1987														
		25b. REGISTRAR'S SIGNATURE Julia Blawie Landale														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove care tag(s) from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 903-355-6444.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8708289	
1. DECEASED NAME (TYPE OR PRINT)	FIRST Helen	MIDDLE Fay	LAST Crutchley	2a. DATE OF DEATH MONTH DAY YEAR 03/07/87	2b. HOUR 5:55 PM
3. SEX <b>F</b> emale	4. RACE <b>W</b> White	5. DATE OF BIRTH MONTH DAY YEAR 6 02 26.	6. AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEM. HOSR.</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Child Care</b>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>212 S. Carroll Street/ 21701</b>	
14. FATHER'S NAME FIRST <b>Raymond</b>	MIDDLE <b>Null</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b>	MIDDLE <b>Long</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>	16c. INFORMANT <b>Harry E. Crutchley, Frederick, Md. 21701</b>	17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT, RECURRENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIAL SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> . Several months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>INTRACTABLE HEART FAILURE, DIABETES MELLITUS, OREMIA RT BK AMPUTATION</u>					
19a. DATE OF OPERATION <b>2-3-87</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RT BELOW AMPUTATION KENSON</b>	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>NA</b> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NA</b>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) <b>NA</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <b>NA</b>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM) <b>NA</b>	21f. LOCATION STREET <b>A</b>	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>3-7 1987</b> , to <b>3-7 1987</b> , that (I) (we) last saw the deceased alive, an above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Abdul Majeed</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL MAJEED</b>	22e. DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3-7-87</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Mar 11, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION CITY, TOWN, COUNTY <b>Frederick, Frederick, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>	ADDRESS <b>106 East Church Street, Frederick, Md. 21701</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1987</b>	25b. REGISTRAR'S SIGNATURE <b>John T. Johnson</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be paged at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08290					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
CHARLES IRVING DANNER						MARCH			1	1987		4:27P M					
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			Caucasian	MONTH	DAY	YEAR	82			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			U.S.A.						Frederick MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Frederick			334 Park Ave.,			Retired Gov't											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		334 Park Ave./ 21701									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
			Charles	Irving	Danner	Carrie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			217-10-0663			Mrs. Nanearl Danner			334 Park Ave. Frederick, Md. 21701								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer												APPROXIMATE INTERVAL BETWEEN DEATH AND AUTOPSY					
DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis												months					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) lost sow the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.									21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22b. SIGNATURE									21g. DEGREE								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3-4-1987						
Alton J. Gibson									22e. ADDRESS 1475 Taney Ave. Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE				
Burial			March 4, 1987			Mount Olivet Cem.			Frederick			Frederick	Md.				
24a. FUNERAL DIRECTOR Robert E. Dailey & Son PA												25a. ADDRESS 1201 N. Market Frederick, Md.		25b. DATE REC'D. BY REGISTRAR MAR 19 1987		25b. REGISTRAR'S SIGNATURE John R. Anderson	
DHMH - 16 60M 7/84 (VRA 15, 4)																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

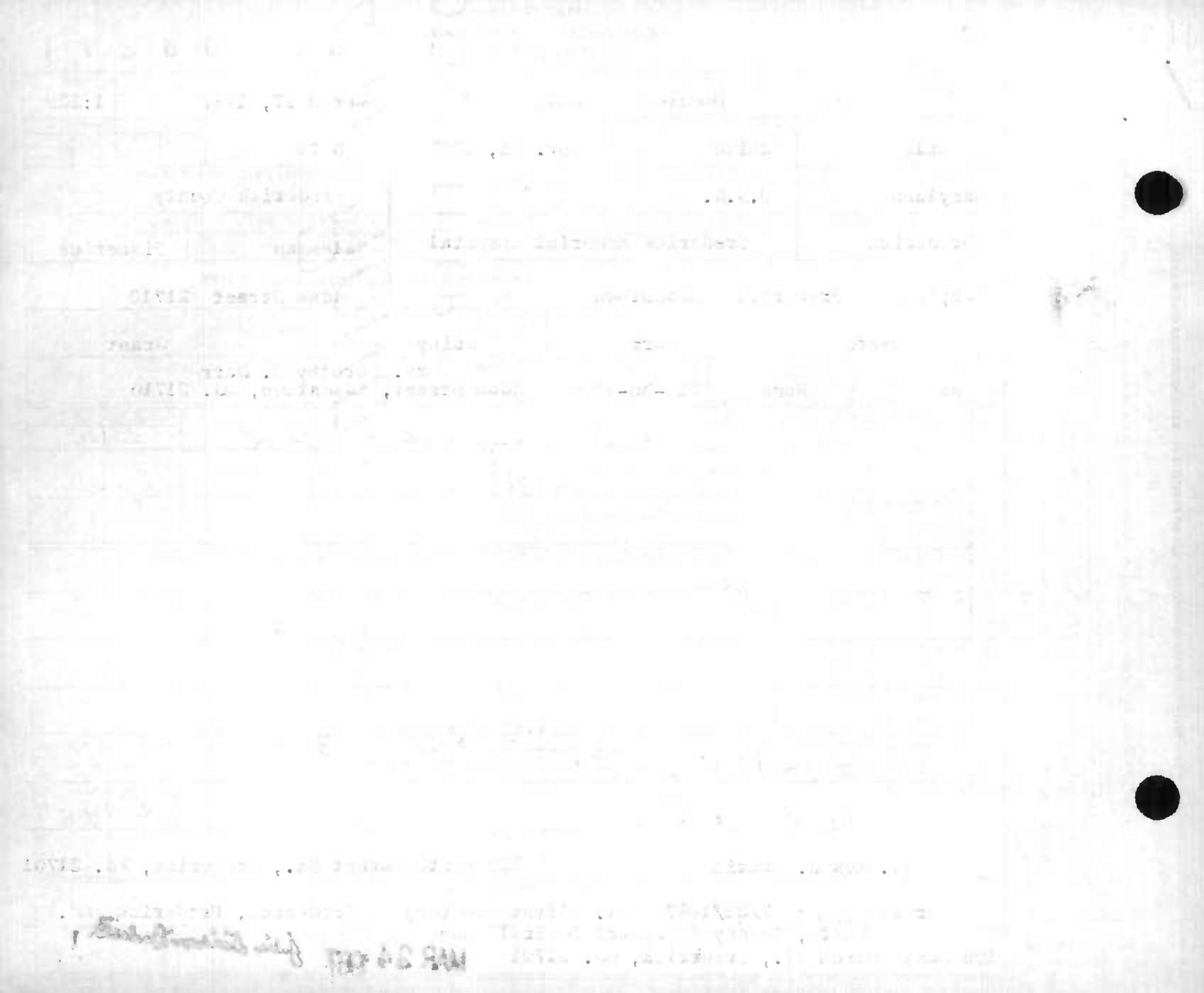
BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this certificate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8708291 REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <b>Leo Howard DARR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1987</b>			2b. HOUR <b>1:32P M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 21, 1907</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b>			MD.
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fisheries</b>
13. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Adamstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Adam Street 21710</b>	
14. FATHER'S NAME FIRST <b>Howard</b>		MIDDLE <b>Darr</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Daisy</b>	LAST <b>Grant</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None 218-30-8809</b>		17. INFORMANT Mrs. Dorothy G. Darr ADDRESS <b>Adam Street, Adamstown, Md. 21710</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASHD</i>				<i>yes</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>age</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>10-5-53</i> to <i>3-17-</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>1-19</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Rex R. Martin</i>		DEGREE			22c. DATE SIGNED <i>3-19-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Rex R. Martin</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <b>220 North Market St., Frederick, Md. 21701</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/21/1987</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Frederick, Frederick, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>			25b. REGISTRAR <i>Julie DeLoach</i>	
106 East Church St., Frederick, Md. 21701						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires  
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A death certificate be executed within 24 hours after death. Page 4 may be

## MEDICAL CERTIFICATION

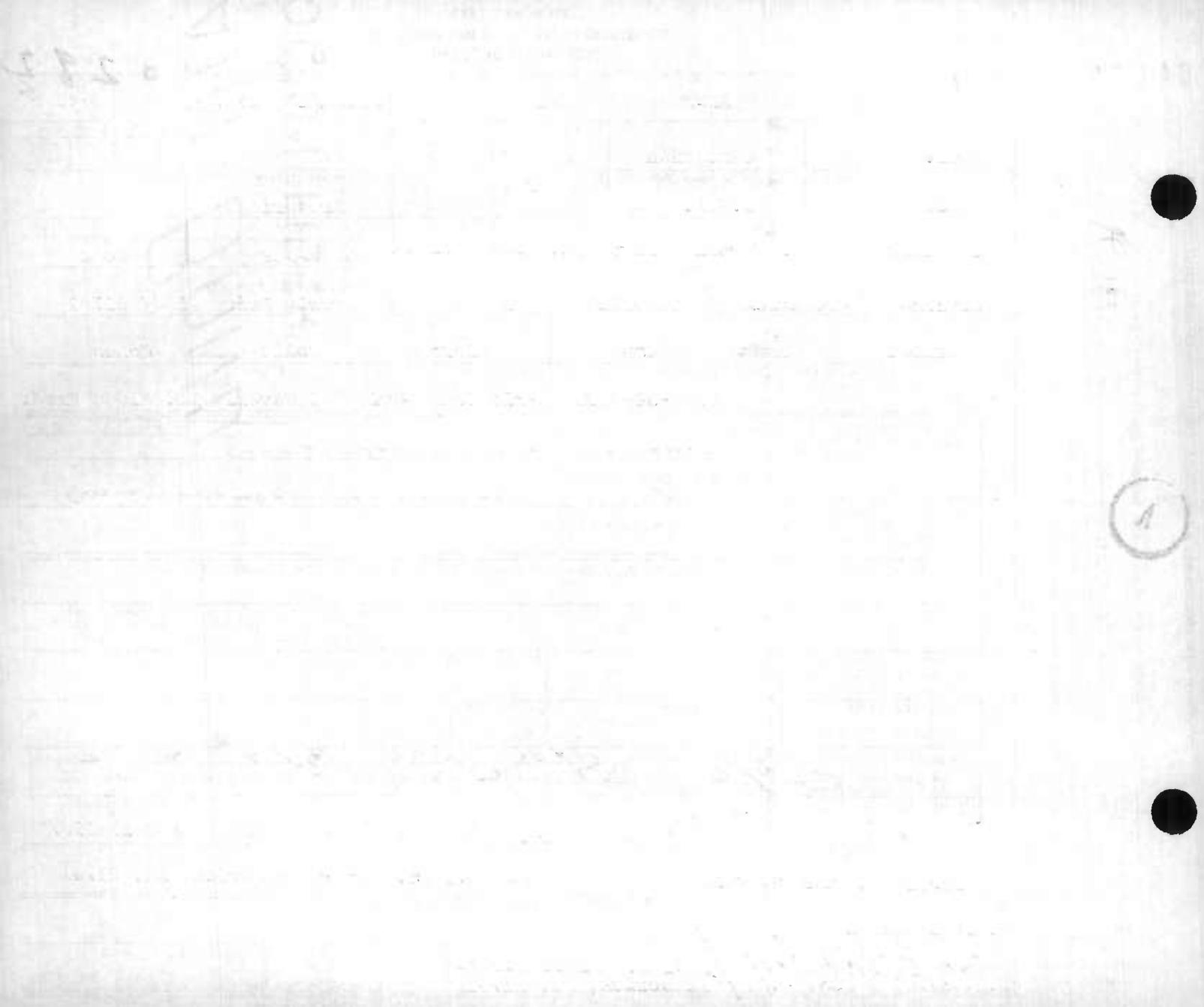
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 3 292  
9:45 a.m.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>JO</b>	MIDDLE <b>ANNE</b>	LAST <b>DAVIS</b>	2a. DATE OF DEATH <b>March 19, 1987</b>	MONTH YEAR	DAY	YEAR	HOUR	
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>03</b>	DAY <b>04</b>	YEAR <b>40</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2 Waverly Drive Apt. #104 Build.K</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2 Waverly Drive #104/ 21701</b>				
14. FATHER'S NAME FIRST <b>Ernest</b>			MIDDLE <b>Joseph</b>	LAST <b>Stone</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b>		MIDDLE <b>Belle</b>	LAST <b>Jones</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>289-34-0533</b>		17. INFORMANT <b>Carla Jane Davis</b>		ADDRESS <b>2 Waverly Dr. K104, Fred.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive liver cirrhosis</b>			DUE TO, OR AS A CONSEQUENCE OF (b) <b>poor B-pore condition</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>3/6 1982</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/6 1982</b> , to <b>3/19 1982</b> , that (we) lost the deceased alive on <b>3/6 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>G.P. Rausch</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-19-1987</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory P. Rausch, M.D.</b>		22e. ADDRESS <b>4 West 7th Street Frederick, Md. 21701</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal-Burial</b>		23b. DATE <b>7</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>1201 Market Street</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR <b>R.E. DAILEY &amp; SON, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1987</b>		25b. REGISTRAR'S SIGNATURE <b>L. King, Regist.</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use on the Burial Permit. Then please return to the funeral director. This certificate is valid for 30 days from the date it is signed, unless filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or general.

IMPORTANT: If Item 21a is marked or Item 22a is checked, then any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REC. NO. 0 8 2 9		
1. DECEASED NAME <b>ANNA</b>			FIRST <b>IRENE</b>	MIDDLE <b>DeBERRY</b>	LAST	2a. DATE OF DEATH <b>MARCH 17, 1987</b>	MONTH DAY YEAR	2b. HOUR M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>4</b> YEAR <b>1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK, COUNTY</b>	MD.				
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>WALKERSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>9503 HIGHLANDER CIRCLE/ 21793</b>				
14. FATHER'S NAME <b>GUY</b> FIRST	MIDDLE <b>THOMAS</b>	LAST <b>SMITH</b>	15. MOTHER'S MAIDEN NAME <b>ANNIE</b>	MIDDLE <b>RUTH</b>	LAST <b>WINPIGLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NONE</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE BIRTH DATES) <b>NONE</b>	16c. 213-16-0156	17. INFORMANT <b>RAYMOND C. DeBERRY</b>	ADDRESS <b>9503 HIGHLANDER CIRCLE WALKERSVILLE, MD. 21793</b>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral respiratory arrest</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral hemorrhage</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypotension</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>IntraCerebral hematoma</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Swami Nathan MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3-18-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Swami NATHAN, MD</b>	22e. ADDRESS <b>207 W 7 Sr. Frederick, Md 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3/20/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>BLUE RIDGE CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>THURMONT</b>	COUNTY <b>FREDERICK</b>	STATE <b>MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <i>Robert E. Datley</i>	ADDRESS <b>615 E. MAIN ST. ROBERT E. DATLEY &amp; SON, P.A. THURMONT, MD. 21788</b>	25a. DATE REC'D. BY REGISTRAR <b>APR - 2 1987</b>	25b. REGISTRAR'S SIGNATURE <i>Lia David-Randall</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury or other traumatic event, the medical examiner may be notified thereof.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 08294														
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR					
			Genevieve YORK Delaney						3 26 87					
3. SEX FEMALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS					
						12 21 1917			69 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD.					
10. CITY OR TOWN OF DEATH FREDERICK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY FREDERICK			13c. CITY OR TOWN THURMONT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7195 Prospect Drive, 21788		
14. FATHER'S NAME FIRST CLARE MIDDLE YORK LAST			15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE HENRIETTA LAST BURLINGAME											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Joseph Delaney			ADDRESS Thurmont, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b)											
			(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Tumour - Recurred</i>														
19a. DATE OF OPERATION February 1987			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumour Cancer			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>saw the deceased alive on March 26 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Lloyd H. Lusk</i>			22c. DEGREE						22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd H. Lusk			22e. ADDRESS 1475 Tandy Ave., Frederick			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/28/87			23c. NAME OF CEMETERY OR CREMATORIUM Resthaven Crematory			23d. LOCATION CITY OR TOWN Frederick COUNTY Frederick STATE MD					
24. FUNERAL DIRECTOR G. DOUGLAS STAUFFER NAME ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701														
25a. DATE REC'D. BY REGISTRAR APR-2 1987			25b. REGISTRAR'S SIGNATURE <i>Jane Darden-Lusk</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the burial transit permit. Then please remove carbon papers. Pages should be detached for use as the burial transit permit. Then please remove carbon papers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

MAR 31 19

Film #G627, Items #1,2a,2b,8,11,12b,14. STATE OF MARYLAND  
EOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
STATE 15, and 16a, 5/5/87, sjb CERTIFICATE OF DEATH  
REGISTRAR (ok cor. qb)

REG. NO.

08295

I DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Purd			E. Eugene			Deitz			3 3 - 4 - 87			2:40 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		Oct. 22, 1897			89			MONTHS DAYS		HOURS MIN.					
7. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Penns.		U.S.A.					Frederick Co.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Retirement Homewood Retirement Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		Church Religion					
Frederick							Minister										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE											
Maryland						13b. COUNTY Washington											
13c. CITY OR TOWN Williamsport						13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>											
13e. STREET ADDRESS / ZIP CODE 21795																	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST Harry			MIDDLE W. Deitz			LAST Dietz			FIRST Ada			MIDDLE G.					
LAST Gilbert																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT					
No						493-40-5815						Barbara D. Mehl 2818 Wildwood Court Walkersville, Md					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Pneumonia (bacterial - respiratory)												1 week					
DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease												?					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12-9-1986 to 3-4-1987, that (I/we) last saw the deceased alive on 3-3-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.												22c. DATE SIGNED 3-4-87					
22b. SIGNATURE <i>George L. Smith</i>			DEGREE R.O.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 3-4-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/5/87			23c. NAME OF CEMETERY OR CREMATORIAL Rosedale Funeral Ch			23d. LOCATION CITY OR TOWN Martinsburg			COUNTY Berkeley		STATE WV			
24. FUNERAL DIRECTOR NAME Alva D. Linder			ADDRESS Rt. #7, Martinsburg			25a. DATE REC'D. BY REGISTRAR MAR 24 1987			25b. DATE REC'D. BY CLERK								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification portion of this certificate must be completed before this certificate can be filed within 72 hours after death.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 / 0 8 2 9 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21b. HOUR	
Lester Clarence Dinterman						MARCH 21, 1987				7:55 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Nov. 22, 1911 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.	
7b. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County					
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Price Elec. Co.		
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Walkersville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 33 Maple Ave., 21793			
14. FATHER'S NAME FIRST Clarence			MIDDLE Lester		LAST Dinterman	15. MOTHER'S MAIDEN NAME FIRST Florence			MIDDLE Grace	LAST Clabaugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) None			17. INFORMANT Mrs. Olive C. Dinterman 33 Maple Ave., Walkersville, Md. 21793			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Excessive post-stroke complications</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>102</i> , 1987, to <i>3/01</i> , 1987, that (I) (we) lost sow the deceased alive on <i>3/21</i> , 1987, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.											
22b. SIGNATURE <i>Rausch</i>						DEGREE					
22c. ATTENDING PHYSICIAN <input type="checkbox"/>						MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/21/87</i>	
22e. ADDRESS Dr. P. Gregory Rausch						4 West Seventh St., Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial</i> <i>102</i> , 1987		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens		23d. LOCATION CITY OR TOWN Frederick		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <i>Smith, Keehey &amp; Basford Funeral Home</i> ADDRESS <i>106 East Church St., Frederick, Md. 21701</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Denton-Lindner</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8708291					
					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Katherine	V.		Fisher	March 23, 1987			a. 8:38			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.	
Female	White	Month Day Year Feb. 23, 1908			79 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland	U.S.A.				Frederick					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Frederick	Frederick Memorial Hospital			Housewife			Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13e. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			200 E. 16th Street 21701				
Maryland	Frederick	Frederick								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
	Harry	S.	Butt	Levinia			Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS					
No	217 30 0796	Edwin F. Fisher (son) P.O. Box 3269 Frederick, Md.			21701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>Rupture rectum - colon - peritonitis - sepsis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>rupture rectum -</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>poor cardiac status - coronary Disease</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
3/22/87	<u>perforation rectum - colon</u>			<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/7</u> , 19 <u>87</u> , to <u>3/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Nicholas P. Foris</u>					DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NICHOLAS P. FORIS</u>					22e. ADDRESS <u>27 W. 7th St. Frederick - MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNT		
Burial	3/25/87	Potomac United Methodist Church Cemetery, Potomac, Md.								
24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> ADDRESS <u>1331 Rockville Pike, Rockville, Md. 20852</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 27 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Lia Jordan Radde</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **Attempted Suicide**, show any injury, or other traumatic event, the medical examiner must be notified before this certificate is filed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8708298		
1 - STATE REGISTRAR FOR 1 - DECEASED NAME (TYPE OR PRINT) Mary Rosa Lee GEISER			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR March 29, 1987			2b. HOUR 9:00 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1904			6. AGE IN YEARS LAST BIRTHDAY 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 Mary Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 603 Mary Street, 21701				
14. FATHER'S NAME FIRST: Jacob MIDDLE: A. LAST: Kidwiler					15. MOTHER'S MAIDEN NAME FIRST: Elizabeth MIDDLE: Ann LAST: Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. None 216-54-7811			17. INFORMANT Thomas M. Geiser, 24 Norva Avenue Frederick, Md. 21701		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>congestive heart failure</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John A. Vitarello</i>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED APR 02 1987				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John A. Vitarello, M.D.		22e. ADDRESS 335 Park Ave., Frederick, Maryland 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 1, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701					25a. DATE REC'D. BY REGISTRAR APR 02 1987			25b. REGISTRAR'S SIGNATURE <i>Julie Wilson-Bailey</i>				

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100 20 90A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon and ink from the signature line. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												08299					
												REG. NO.					
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR					
		Charlotte A.						Goodrich		3/30/87 3 30 87		6:30 AM					
		Charlotte A.		Goodrich													
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH		1/31/03		6. AGE (IN YEARS LAST BIRTHDAY)		84		IF UNDER 1 YEAR MONTHS DAYS					
Female		Caucasian		1		31 03		84		YRS.		IF UNDER 24 HRS MONTHS HOURS MIN.					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland Balt. City		US USA						Frederick County									
10. CITY OR TOWN OF DEATH Fred. md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
		Meridian Nursing Center Frederick		Teacher		Public School											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1819 Beaver Creek Lane 21701									
14. FATHER'S NAME Adolf		14b. MIDDLE H.		14c. LAST Fischer		15. MOTHER'S MAIDEN NAME Minnie		Hoerning									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. N/A		16c. ADDRESS 214-38-9080		17. INFORMANT Charlotte A. Hoover		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of Lung</i>																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <i></i>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  19a. DATE OF OPERATION																	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED																	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (in this hospital) attended the deceased from <i>3/14/87</i> 19 to <i>3/30/87</i> , that (I) (we) last saw the deceased alive on <i>3/14/87</i> 19, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																	
22b. SIGNATURE <i>Robert L. Kaufmann, MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/30/87</i>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Robert L. Kaufmann, M.D.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/02/87		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		23d. LOCATION CITY OR TOWN Baltimore City, Maryland							
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, MD		25a. DATE REC'D. BY REGISTRAR MAR 31 1987		25b. REGISTRAR'S SIGNATURE <i>MacNabb Funeral Home</i>											
DHMH - 16 60M 7/84 (VRA 15, 4)																	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08300	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Robert Glessner Green						3 1 87						19:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		07 11 1920			66 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.						
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comp. Programmer			12b. KIND OF BUSINESS OR INDUSTRY US Govern.						
13a. STATE MD		13b. COUNTY Frederick		13c. CITY OR TOWN Walkersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8512 Fountain Rock Court, 21793					
14. FATHER'S NAME JOHN		MIDDLE	WILLIAM	LAST	GREEN	15. MOTHER'S MAIDEN NAME CLARA		MIDDLE	LAST	JACKSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Doris Green			ADDRESS Walkersville, MD 8512 Fountain Rock Court						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Squamous Cell Carcinoma of Tongue</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 31187			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>3/11/87</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Robert L. Kaufmann</i>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN ROBERT L. KAUFMANN			22e. STAFF PHYSICIAN DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22f. DATE SIGNED <i>3/11/87</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/5/87		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick		23e. COUNTY Frederick			23f. STATE MD	
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown PIke, Frederick, MD 21701								25a. DATE REC'D. BY REGISTRAR MAR 06 1987		25b. REGISTRAR'S SIGNATURE <i>Deborah Landale</i>			

20.6 GOMBERG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the coroner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1 - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) <b>LEAH NAOMI GRUBER</b>				2b. DATE OF DEATH MONTH DAY YEAR				2b. HOUR				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b>		YRS.		MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>MERIDIAN NURSING HOME</b>		12a. USUAL OCCUPATION <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR TRADE <b>HOME</b>		MD.				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD STATE <b>FREDERICK</b>		13. RESIDENCE ADDRESS <b>WOODSBORO</b>		13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. RESIDENCE ADDRESS <b>10911 GRUBER RD.</b>		21798				
14. FATHER'S NAME <b>JESSE FOX</b>		15. MOTHER'S MAIDEN NAME <b>MARTHA L. FOGLE</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO NO OR UNKNOWN		16b. SOCIAL SECURITY NO. <b>219-36-4816</b>		17. INFORMANT <b>HARRY C. GRUBER JR.</b>		ADDRESS <b>P.O. BOX 102 WOODSBORO, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for part (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic Cardiovascular Disease</b> 10 years												
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hyperension, Cardiovascular disease, Diabetes Mellitus</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hyperension, Cardiovascular disease, Diabetes Mellitus</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 57		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) this hospital attended the deceased from 19 57, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) will did not view the body after death.												
22b. SIGNATURE <b>LASPER E. CLINE MD</b>		22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>804 Toll House Ave</b>				22f. DATE SIGNED <b>3/30/87</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>04/01/87</b>		23c. STATE OF CEMETERY OR CREAMATORY <b>BLUE RIDGE CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>THURMONT FREDERICK STAND</b>						
24. FUNERAL DIRECTOR <b>D. HARTZLER</b>		25a. ADDRESS <b>WOODSBORO, MD</b>		25b. DATE REC'D. BY REGISTRAR <b>APR 2 1987</b>		25c. REGISTRAR'S SIGNATURE <b>John David Landale</b>						

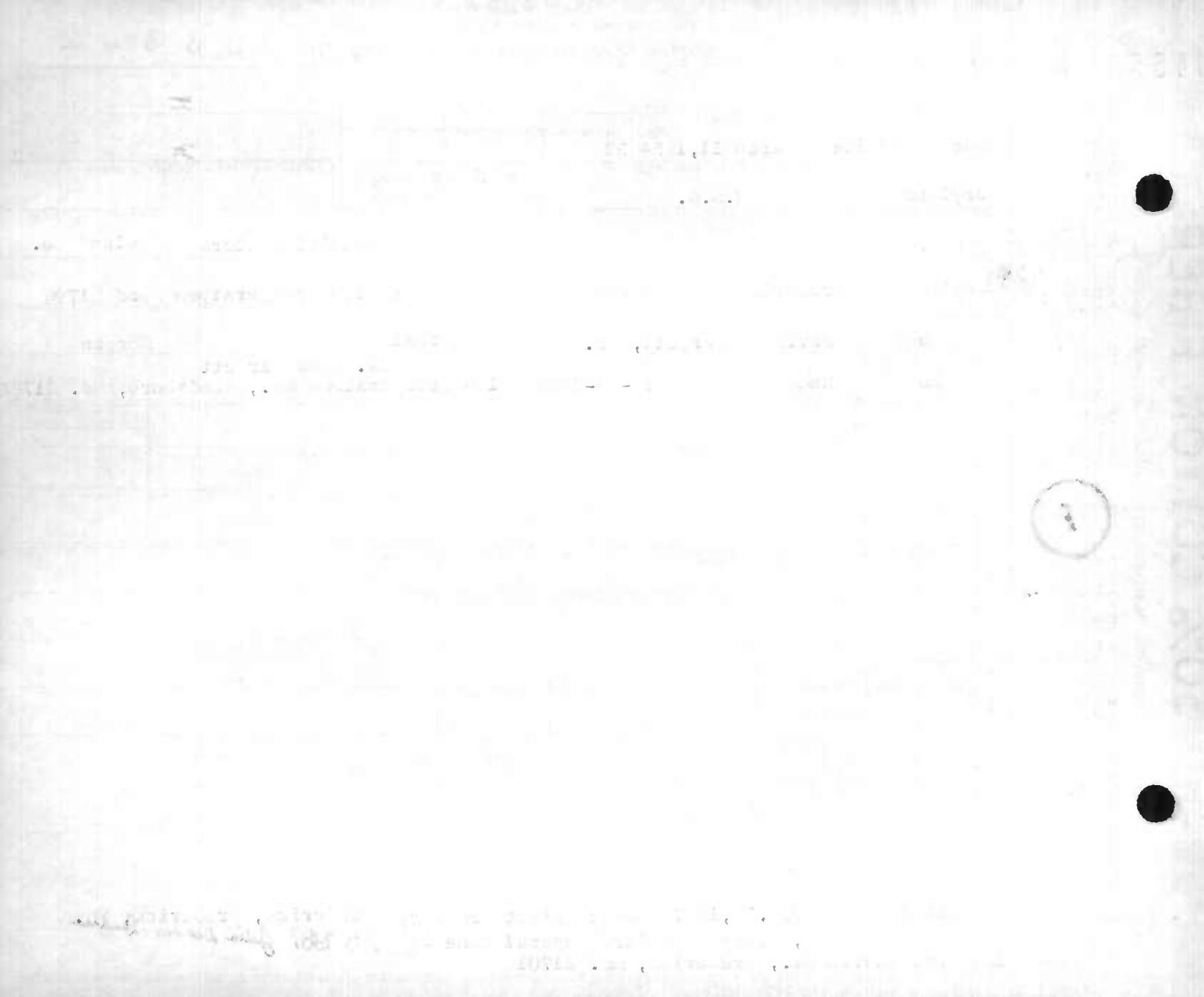
4/9

(1)

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGES 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

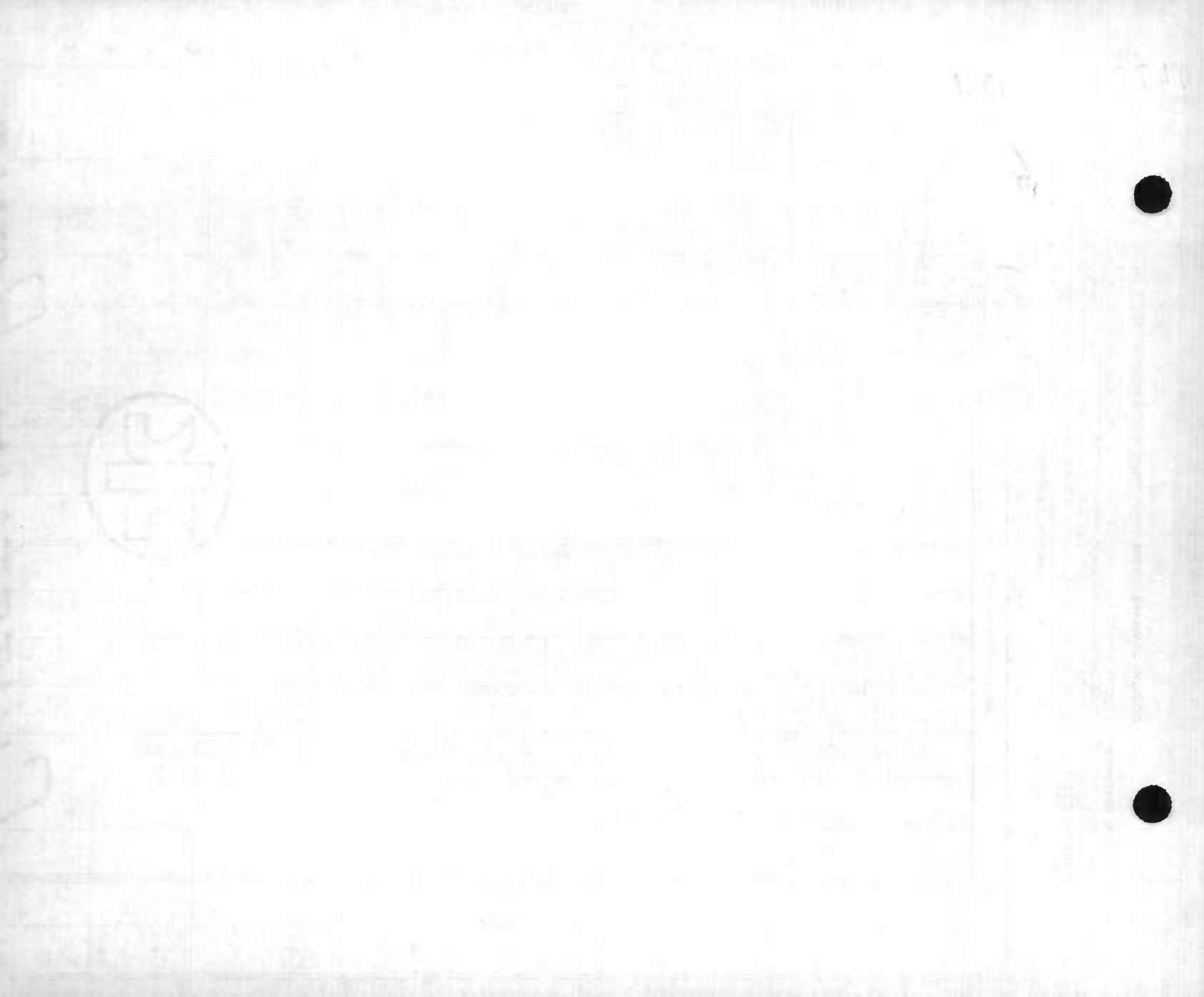
DEPARTMENT OF HEALTH AND MENTAL HYGIENE <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>												REG. NO. 08302					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH MONTH	DAY	YEAR	2b. HOUR 2d HOUR	
RICHARD			A.						HARGETT			<input checked="" type="checkbox"/>	2	20	19	87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD	2d. MONTH MONTH	DAY	YEAR	2d. HOUR 7:29 AM			
Male	White	March 11, 1954	32 yrs							2	20	19	87				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.									Frederick County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Frederick		Frederick Memorial Hosp. (DOA)						Receiving Clerk			Noland Co.						
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Woodsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
								106 Creagerstown Road 21798									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Hugh		David		Hargett, Sr.		Mabel				Morgan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		None		216-60-7888		Mrs. Tana Hargett		106 Creagerstown Rd., Woodsboro, Md. 21798									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head trauma 9192 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
7:10 AM 2-20- 1987		Operator of fork lift that overturned on															
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		subject.		Frederick							
		Noland Co.		600 S. Market St.				COUNTY		MD							
22a. I certify that I have charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 2-20-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
Burial		Feb. 23, 1987		Mount Olivet Cemetery		Frederick		Frederick		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF DEATH FEB 25 1987		25b. CEMETERY OR CREMATORIUM SIGNATURE		25c. COUNTY		STATE							
Smith, Keeney & Basford Funeral Home																	
106 East Church St., Frederick, Md. 21701																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, WITH FORM P.M. 3. RETAIN A PAPER COPY FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN A PAPER COPY FOR YOUR FILES.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REV. NO. 08303											
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)						FIRST			MIDDLE		LAST			2a. DATE KNOWN OF ESTI. DEATH MATED		2b. MONTH DAY YEAR	2d. HOUR			
			John Elliott Heath														<input checked="" type="checkbox"/>		3-7-87 19	M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR				
Male		White		09 15 1960			26 yrs.									3-7		19 87	11:08 p.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
ENGLAND			USA									Frederick County											
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY								
Frederick			Frederick Memorial Hospital						SALESMAN						99999								
11. PREVIOUS RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. MOTHER'S MAIDEN NAME			15. FATHER'S NAME								
STATE VA			COUNTY Loudoun			Sterling			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			400 Drew Court			FIRST Edward MIDDLE Dixon LAST Heath			FIRST Claire MIDDLE Stitle LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Cranio-cerebral Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Cranio-cerebral Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 10:00 PM 3-7 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21e. LOCATION STREET Rt. 15 & Mountville Rd.			21f. CITY OR TOWN			21g. COUNTY Frederick Co			21h. STATE MD		
22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE Charles P. Kokes, M.D.			TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER			DATE SIGNED 3-9-87																	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto., MD 21201																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/11/87			23c. NAME OF CEMETERY OR CREMATORIAL RESTHAVEN Mem. Gardens			23d. LOCATION CITY OR TOWN Frederick			23e. COUNTY Frederick			23f. STATE MD								
BURIAL																							
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD 21701			25a. DATE REC'D. BY REGISTRAR MAR 12 1987						25b. REGISTRAR'S SIGNATURE Maria J. Gordon-Pandare														



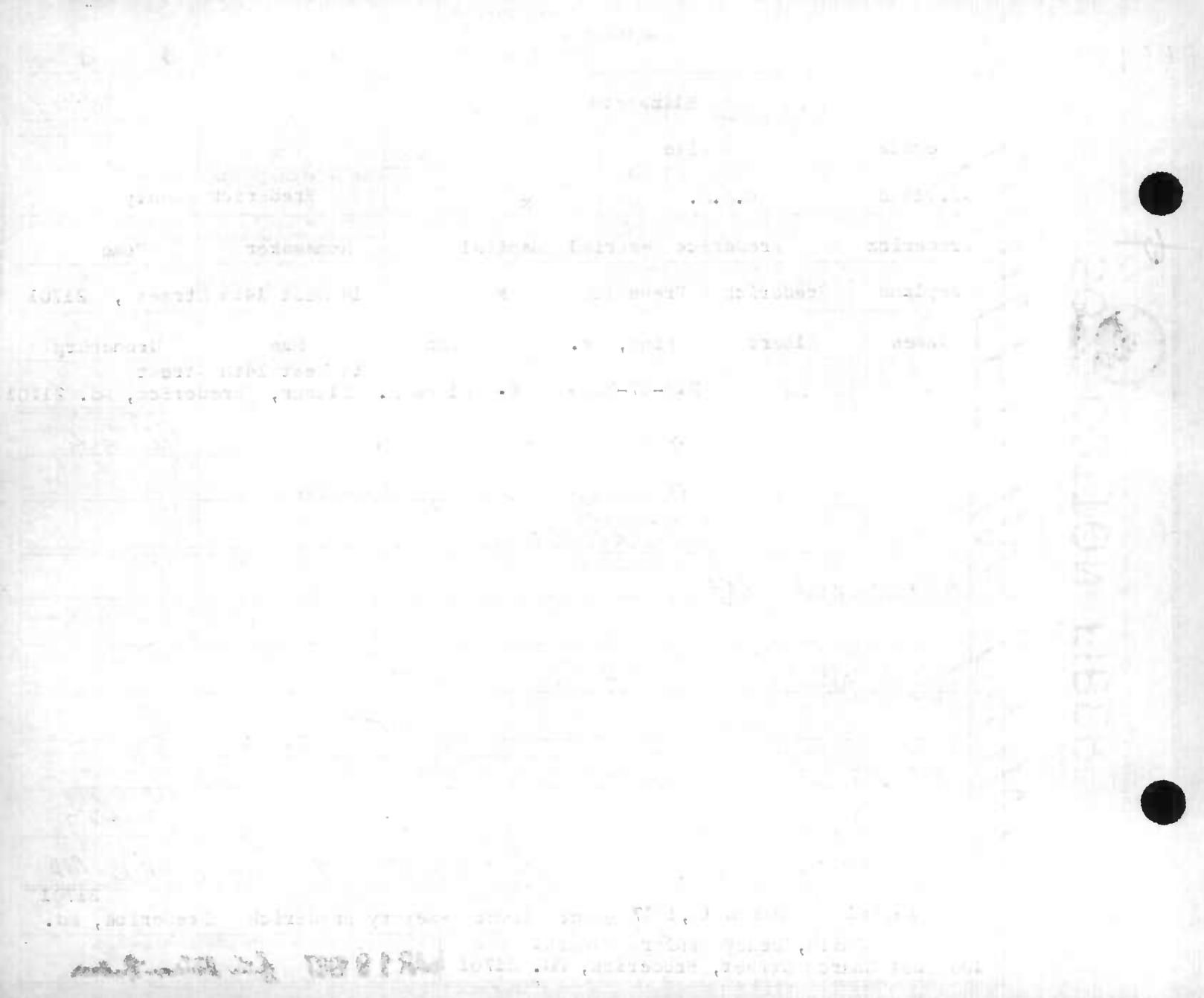
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be given to you within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the burial permit issued by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please note that this certificate must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 08304														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>BLANCHE Elizabeth HILTNER</i>						<i>3/14/87</i>						<i>8:30 PM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>White</i>		MONTH	DAY	YEAR	<i>82</i>			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Maryland</i>		<i>U.S.A.</i>					<i>Frederick County</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Frederick</i>		<i>Frederick Memorial Hospital</i>		<i>Homemaker</i>			<i>Home</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE				
<i>Maryland</i>		<i>Frederick</i>		<i>Frederick</i>						<i>14 West 14th Street, 21701</i>				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	16. SOCIAL SECURITY NO.				17. INFORMANT	
<i>James</i>		<i>Albert</i>	<i>King, Sr.</i>	<i>Rosa</i>			<i>Mae</i>		<i>219-07-2864</i>				<i>Mr. Roland R. Hiltner, Frederick, Md. 21701</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few mts.</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease.</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>Recurrent CVA</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>NA</i> 19			21c. HOW INJURY OCCURRED <i>NA</i>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>NA</i>			21f. LOCATION STREET <i>NA</i>			CITY OR TOWN <i>NA</i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> , 19 <i>87</i> , to <i>3.14</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Bernard</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>3.14.87</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABOVE MAILED</i>		22e. ADDRESS <i>4E CHURCH St. Frederick MD</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 18, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery			23d. LOCATION CITY OR TOWN <i>Frederick</i> COUNTY <i>Frederick</i> STATE <i>MD</i>			23e. DATE REC'D. BY REGISTRAR <i>MAR 19 1987</i>				
24. FUNERAL DIRECTOR NAME <i>Smith, Keeney &amp; Basford Funeral Home</i> ADDRESS <i>106 East Church Street, Frederick, Md. 21701</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 19 1987</i>			25b. REGISTRAR'S SIGNATURE <i>John Smith</i>									

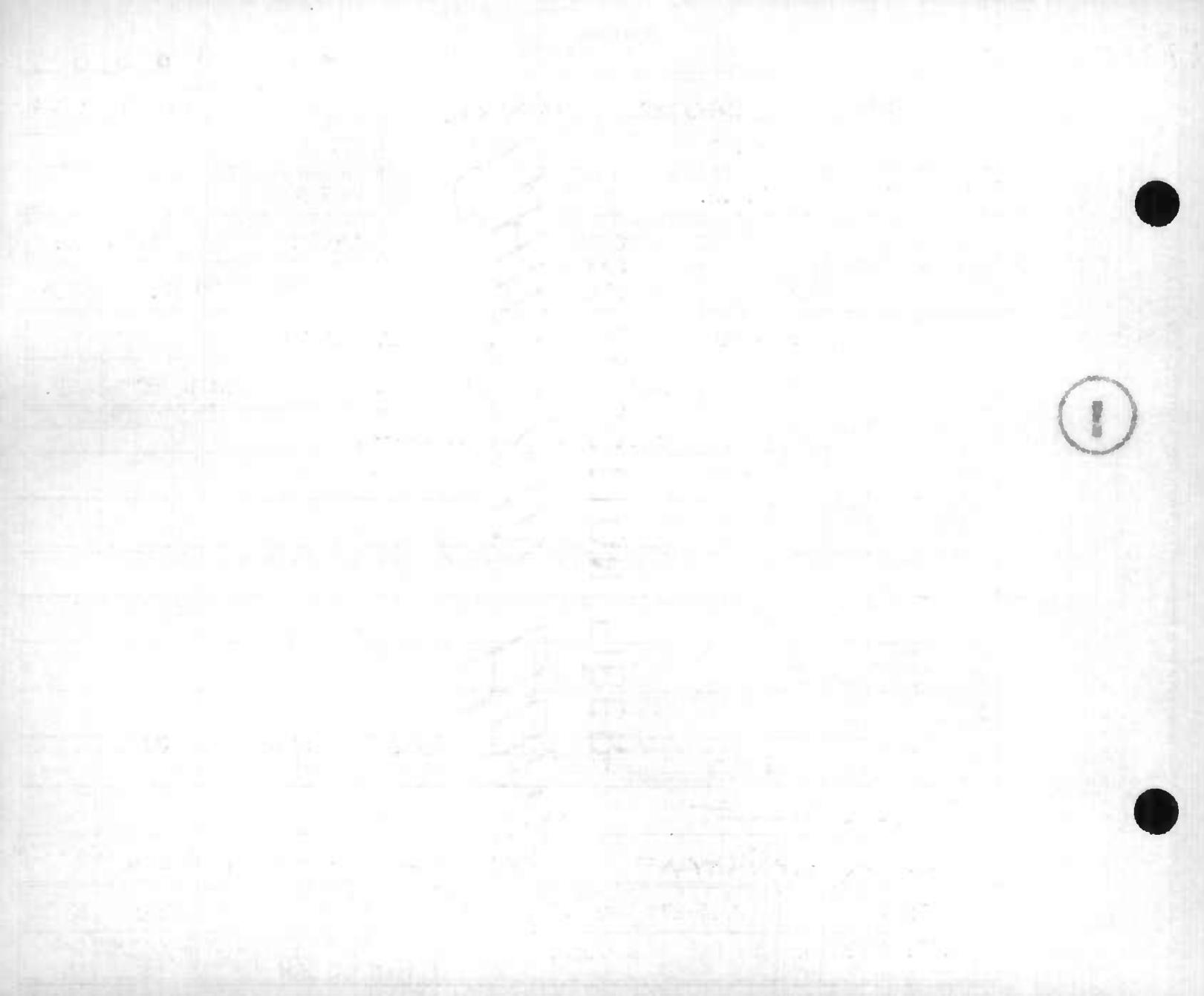


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use on the burial permit. Then please remove carbon copies. Return 1 and 2 should be filed with 3 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked on Item 18.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 REG. NO. 08305											
1. DECEASED NAME (TYPE OR PRINT)			FIRST: JAMES	MIDDLE: BARNES	LAST: HORNER	2a. DATE OF DEATH			MONTH: APR	DAY: 14	YEAR: 87
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 09/09/15			6. AGE (IN YEARS LAST BIRTHDAY) 71		
7a. BIRTHPLACE MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK		
10. CITY OR TOWN OF DEATH FREDERICK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FREDERICK MEMORIAL			12a. USUAL OCCUPATION LABORER			12b. KIND OF BUSINESS OR INDUSTRY PAVING CO.		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) STATE: MD COUNTY: FREDERICK CITY OR TOWN: WOODSBORO						14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12c. STREET ADDRESS, ZIP CODE 10331 WOODSBORO RD. 21798		
14. FATHER'S NAME CHARLES WILLIAM HORNER						15. MOTHER'S MAIDEN NAME JENNY GERTRUDE SMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN <input checked="" type="checkbox"/> WW II			16b. SOCIAL SECURITY NO. 212-14-7939			17. INFORMANT AUBREY HORNER			ADDRESS 10331 WOODSBORO RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac hemorrhage</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 19 87</i> to <i>21 14 19 87</i> , that (I) (we) last saw the deceased alive on <i>3-14 19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>B. Barakat</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>Mar 19 1987</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kusay BARAKAT</i>			22f. ADDRESS <i>335 Park Avenue Frederick MD 21701</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 03/17/87			23c. NAME OF CEMETERY OR CREMATORIAL OAK HILL CEMETERY			23d. LOCATION CITY, TOWN, STATE FREDERICK MD		
24. FUNERAL DIRECTOR D.N.D. HARTZLER			25a. DATE REC'D. BY REGISTRAR MAR 19 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sanders Leader</i>					
BP _____			WOODSBORO, MD								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 08106	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT) <b>Dennis Harry HUGHES</b>			March 23, 1987			4:00P M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>NOV. 24, 1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b>	
						IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>37 East Second Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Harry</b>		MIDDLE <b>Joseph</b>		LAST <b>Hughes</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mabel</b>	
MIDDLE <b>Ruth</b>		LAST <b>Hanson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		16c. SOCIAL SECURITY NO. <b>475-42-4991</b>		17. INFORMANT <b>James J. Hughes</b> ADDRESS <b>4833 Hargett Lane Frederick, Md. 21701</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AIDS</b>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>316</b>		21f. LOCATION STREET <b>3123</b>		CITY OR TOWN <b>1987</b>	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. Shapiro, M.D.</b>							
DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22c. DATE SIGNED <b>3/24/87</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Philip Shapiro</b>		22e. ADDRESS <b>814 Toll House Ave., Frederick, Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/24/1987</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN <b>Smithsburg, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>		ADDRESS <b>106 East Church St., Frederick, Md. 21701</b>		25. DATE REC'D. BY REGISTRAR <b>MAR 31 1987</b>		25. REGISTRAR'S SIGNATURE <b>Julia Dearden-Ladd</b>	



246

RECORDED MAIL  
TOXIC FISH

047562 MAR 10 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please return to the medical examiner or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked  show any injury, or other traumatic event, the medical examiner will be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08301			
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
			GRACE Hill Jacobs						3 7 87			7 15 PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
F			N 2			MONTH DAY YEAR			82			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Md			US						Frederick						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Braddock Heights			Vindobona Nursing Home			DEAN OF College			Education			21701			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Md			Frederick			Kmorville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1624A Jefferson Pk.			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
Daniel Grafton			Hill			Margaret Peck									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			220-36-1560			Esther Bailey, 4213 Bonner Rd. Baltimore, Md.						48 hours			
18. CAUSE OF DEATH (Enter only one cause per line for items 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure															
DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse arteriosclerosis															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA COLON															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept 10 19 86 to March 3 19 87, that <input checked="" type="checkbox"/> (we) last law that deceased died on March 3 19 87, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (I) (we) did not view the body after death.															
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED						
L Kinland MD									3-9-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. LOCATION CITY OR TOWN			23b. COUNTY			23c. STATE			
L Kinland			60 NINTH AVE, BRUNSWICK, MD			Suitland, Prince George's, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			
Burial			3/11/87			Lincoln Memorial Cem.			Suitland			Prince George's			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
McClure Funeral Service			7400 Georgia Ave. N.W.			MAR 17 1987			John J. Sander-Kendall						

• recorded off camera from police car

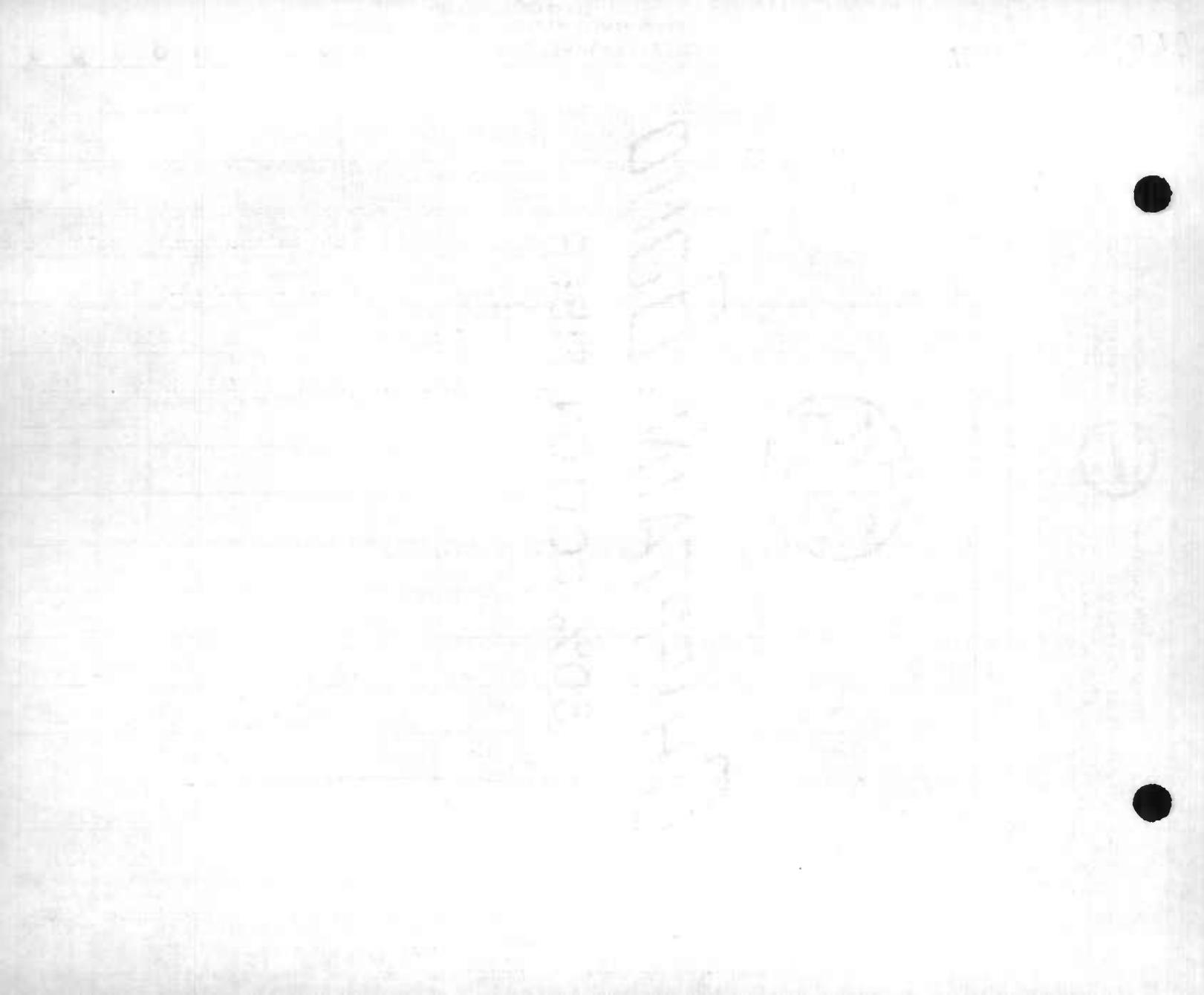
1

• legend points (initials and location stamp) - 1988/2 - 1988/1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENNAL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											REG. NO. 08308
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR	
Susie A. Jordan						<input checked="" type="checkbox"/>	3-2	1987			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	White	11 9 24	62 yrs.	MONTHS	DAYS	HOURS	MIN.			2:45 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		USA					Frederick County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Frederick		Frederick Memorial Hospital					Ret'd Balto. County Health Dept				
13a. STATE West Virginia		13b. COUNTY		13c. CITY OR TOWN Slanesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 128 B Star Rt., 25444			
14. FATHER'S NAME FIRST Denny		MIDDLE Ross		LAST Snedegar		15. MOTHER'S MAIDEN NAME FIRST Florence		LAST Hollingsworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 233-38-5092			17. INFORMANT Keiver R. Jordan			ADDRESS 1 Liwhigh Ave. 21236		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  8161 IMMEDIATE CAUSE (a) <u>Cranio-Cervical Injuries</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 1:30 P.M. 3-2 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in auto which struck an embankment						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 340 west, Frederick, Frederick Co., Md.			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  TITLE (SPECIFY) ASSistant MEDICAL EXAMINER											DATE SIGNED 3-3-87
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Baltimore, Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3-7-87		23c. NAME OF CEMETERY OR CREMATORIAL Emmanuel Lutheran Church Cemetery			23d. LOCATION CITY OR TOWN Westminster		COUNTY Westminster		STATE MD
24. FUNERAL DIRECTOR NAME		Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222			25a. DATE REC'D. BY REGISTRAR MAR 09 1987			25b. REGISTRAR'S SIGNATURE 			

BP  
2PM  
DHMH - 17  
(VR A15 ME (5))



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE OFFICE OF THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE KEPT AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR COPIES TO FUNERAL DIRECTOR, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08309						
1 - STATE REGISTRAR			1-DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR				
			Elsie May Kennedy						OF ESTI- DEATH MATED <input type="checkbox"/> March 21, 1987			7:00 a.m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR	
Female		White		July 31, 1899		87 yrs.						March 21, 1987			7:00 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Frederick County MD.					
Pennsylvania		U.S.A.														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		7896 West Hill Drive						Homemaker			Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Frederick		Frederick				7896 West Hill Dr., 21701								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
Harvey				Morris		Ida				Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		None		212-74-1283		John J. Kennedy		7896 West Hill Dr., Frederick, Md. 21701								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Robert J. Thomas MD</i>		TITLE (SPECIFY) Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>3/22/87</i>		21701						
EXAMINER'S NAME (TYPE OR PRINT) Dr. Robert J. Thomas MD		ADDRESS 812 Toll House Ave., Frederick, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/24/1987		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie, Anne Arundel, Md.		COUNTY		STATE						
24. FUNERAL DIRECTOR'S NAME Smith, Kenneth		24b. ADDRESS 106 East Church St., Frederick, Md. 21701		24c. NAME OF FUNERAL HOME Wesford Funeral Home		24d. DATE REC'D. BY REGISTRAR APR 06 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Darden-Randall</i>								
BP _____																
DHMH - 17 (VR A15 ME (5)) 20M 4/82																

4/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retainer by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 REG. NO. 08310													
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			<b>Sister Gervase Kernan</b>						<b>March 24, 1987</b>			<b>10:05 P.M.</b>	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
<b>Female</b>		<b>White</b>		<b>Jan. 24, 1903</b>			<b>84</b> YRS						
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10b KIND OF BUSINESS OR INDUSTRY			
<b>Md.</b>		<b>U.S.A.</b>					<b>Frederick</b>			<b>Dgtrs. of Charit</b>			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. STREET ADDRESS / ZIP CODE					
<b>Emmitsburg</b>		<b>Villa St. Michael, Emmitsburg, Md.</b>			<b>Teacher</b>			<b>333 S. Seton Avenue</b>					
13a. STATE Md.		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Emmitsburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		<b>21727</b>					
<b>William C. Kernan</b>						<b>Anna Kates</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
<b>No</b>		<b>230-68-2563</b>		<b>Sr. Josephine-Villa St. Michael, Emmitsburg</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cerebrovascular Disease</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arterial Occlusion Distal Right Leg.</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____. that (I) (we) last saw the deceased alive on _____ 19 _____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Alan Carroll MD</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>25 Mar 87</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE								
<b>Alan Carroll, M.D.</b>		<b>S. Seton Ave., Emmitsburg, MD. 21727</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE						
<b>Burial</b>		<b>27 Mar. 87</b>		<b>St. Joseph's</b>			<b>Emmitsburg, Frederick, MD</b>						
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
		<b>Skiles Funeral Home, Emmitsburg, MD 21727</b>			<b>MAR 30 1987 Julie Decker-Landale</b>								
BP													
DHMH - 16 60M 7/84 (VRA 15, 4)													

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www.ijerph.org

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 will be notified of once filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 0831					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruth	MIDDLE Darner	LAST King	2a. DATE OF DEATH MONTH March 24, 1987	DAY YEAR 11:00 P.M.	2b. HOUR P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July 28, 1899 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY County Home					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 118 East Seventh Street, 21701			
14. FATHER'S NAME FIRST Joseph		MIDDLE William		LAST Darner		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE Elizabeth		LAST Himes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ruth E. Etzler, Frederick, Md. 21701		ADDRESS 301 Canberra Court					
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and item 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital defect</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hemorrhagic Cerebral stroke</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b <i>Right breast cancer</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> to <u>1981</u> , that (I) (we) last saw the deceased alive on <u>Mar 24, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Ruth Etzler</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Arthur G. Manalo, M.D.		22e. ADDRESS 187 Thomas Johnson Drive, Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 27, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION CITY/TOWN Jefferson, Frederick, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR MAR 30 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Wilson-Randall</i>							

2000-08-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to him as the funeral director. Then please remove carbon paper from item 1 and 2 should be filled within 24 hours after death.  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked as Item 21a, there is no injury, or other traumatic event, the medical certificate must be obtained.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 08312

1. DECEASED NAME (TYPE OR PRINT)			FIRST Harry	MIDDLE Carl	LAST LAMBRIGHT	2a. DATE OF DEATH March 13, 1987	MONTH MARCH	DAY 13	YEAR 1987	2b. HOUR 11:00 P.M.				
3. SEX Male		4. RACE White	5. DATE OF BIRTH JUNE 3, 1894			6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.							
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home of Fred. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Brush Company							
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 243 East Second St., 21701						
14. FATHER'S NAME FIRST James		MIDDLE Lambright	15. MOTHER'S MAIDEN NAME FIRST Georgianna			MIDDLE Heiser								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None			16c. INFORMANT Mrs. Julia V. Lambright, Frederick, Md. 21701		17. ADDRESS 243 East Second St., Frederick, Md. 21701						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-11/2 yrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Caecum of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Burnt taste</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Intestinal ulcer</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>Sept. 19, 1979</i> , to <i>19</i> , that (I) (we) last saw the deceased alive on <i>3/16/87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
22b. SIGNATURE <i>Robert S. Hughes</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/16/87</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert S. Hughes, M.D.		22e. ADDRESS 700 Montclair Ave., Frederick, Md. 21701												
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE March 17, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick, Frederick, Maryland		23e. COUNTY Frederick			STATE		
24. FUNERAL DIRECTOR <i>Albert C. Basford</i> Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR MAR 20 1987										25b. REGISTRAR'S SIGNATURE <i>John Deacon, Registrar</i>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 8 3 1 5  
1 - STATE REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINCIPAL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECLASSED NAME			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR	REG. NO. 0 8 3 1 5	2b. HOUR
CHARLES			EDWIN	LANTZ		03-27-87 19	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR
MALE	WHTIE	10 25 1930	56 yrs.			3-27-87 19	3:39PM	M
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH
MD		USA						Frederick County
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Frederick		Frederick Memorial Hospital			BRICK MASON			CONSTRUCTION
13a. STATE MD	13b. COUNTY FREDERICK	13c. CITY OR TOWN FREDERICK	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 7224 Bowers Road 21701			
14. FATHER'S NAME FIRST CLARENCE		MIDDLE WILLIAM	LAST LANTZ, SR.	15. MOTHER'S MAIDEN NAME FIRST MARY		MIDDLE CATHERINE	LAST FINNEYFROCK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS Frederick, MD		
NO N/A		218-24-7754		Jean E. Lantz		7224 Bowers Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-27-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled fumes from running car engine				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) detached garage		21f. LOCATION STREET 7224 Bowers Rd.	CITY OR TOWN Frederick, Maryland	COUNTY Frederick	STATE Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Margarita Korell</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/31/87	23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens			23d. LOCATION CITY OR TOWN Frederick, Frederick MD		
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR APR - 2 1987			25b. REGISTRAR'S SIGNATURE <i>Aria Davidson-Randall</i>			

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RIGHT TO INFORMATION ACT  
RECEIVED  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the physician's copy and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove this page and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If Item 21 is marked or if there is any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 0 8 3 1 4				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
17. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			March 22, 1987									2105 P	
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH 10 DAY 11 YEAR 1909			6. AGE (IN YEARS EAST BIRTHDAY) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK MD.</b>							
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>MD</b>			13b. COUNTY <b>FREDERICK</b>			13c. CITY OR TOWN <b>FREDERICK</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>8609 Yellow Springs Rd., 21701</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM H. MOSS</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIE V. HARRIS</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>n/a 217-32-7198</b>			17. INFORMANT <b>Harry L. Linton</b>			ADDRESS <b>Frederick, MD 8609 Yellow Springs Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Massive Pulmonary Embolus</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive malignancy</b>												YEARS				
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>77 years old</b>																
19a. DATE OF OPERATION <b>03/16/87</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cecal Cancer</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b></b>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b></b>			CITY OR TOWN <b></b>			COUNTY <b></b>		STATE <b></b>		
22a. I certify that (I) <b>this hospital</b> attended the deceased from <b>3/15 1987</b> to <b>3/22 1987</b> , that (we) last saw the deceased alive on <b>3/20 1987</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> did not view the body after death.																
22b. SIGNATURE <b>Steven J. Brand</b>			22c. DEGREE <b>MD</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>3/23/87</b>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven J. Brand, MD</b>			22g. ADDRESS <b>27 W. 7th St. Frederick, MD 21701</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/26/87</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Frederick</b>			COUNTY <b>Frederick</b>		STATE <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>G. DOUGLAS STAUFFER</b>			24b. ADDRESS <b>1621 Opossumtown Pike, Frederick, MD 21701</b>			25a. DATE REC'D. BY REGISTRAR <b>APR - 2 1987</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Gordon</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8708315			
												REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			3 - 7-87		0110 A M	
LOUISE BUHRMAN MICHEL															
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			White			MONTH DAY YEAR			80			MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MD.			USA						Frederick Co.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Frederick			Frederick Memorial Hosp.			Hair dresser			Beauty						
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			
MD.			Carroll			Middleburg			YES <input type="checkbox"/> NO <input type="checkbox"/>			21768 5800 Brookfield Manor			
FATHER'S NAME FIRST MIDDLE LAST			Lulu			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Alfred R. Buhrman						Phyllis Buhrman 13e									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no ---			217-26-8069			Phyllis Buhrman			13e			Office 4-528			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coldairic and RESPIRATORY ARREST</u>															
DO TO, OR AS A CONSEQUENCE OF (b) <u>pneumococci MENINGO-ENCEPHALITIS</u>															
DO TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED									20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> , 19 <u>87</u> , to <u>3/7</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/7</u> , 19 <u>87</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE <u>Gary L. Smith Jr.</u>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>3/7/87</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/10/87			23c. NAME OF CEMETERY OR CREMATORIAL St. Mark's			23d. LOCATION CITY OR TOWN Wolfsville Frederick MD						
Burial															
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminister,			ADDRESS 412 Washington Road			25a. DATE REC'D. BY REGISTRAR MAR 17 1987			25b. REGISTRAR'S SIGNATURE <u>Jeanne R. Baker</u>						
BP _____															
DHMH - 16 60M 7/84 (VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. This will release the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, death may be ruled unnatural. In such event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 7 0 8 3 1 6
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR
		JOHN Franklin Miller			APR 06 1987
3. SEX <input checked="" type="checkbox"/> Male		4. RACE <input checked="" type="checkbox"/> White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1909	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7c. IF UNDER 1 YEAR MONTHS DAYS		7d. IF UNDER 24 HRS HOURS MIN.			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD.	
13a. STATE Maryland		13b. COUNTY Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7919 Edgewood Farm Rd., 21701					
14. FATHER'S NAME FIRST Franklin MIDDLE Nimrod LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Della MIDDLE LAST Bowers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1944-1945 214-10-5464 A		17. INFORMANT Charles H. Miller ADDRESS 21701 7919 Edgewood Farm Rd., Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA		DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LONGITUDINAL CARDIOMYOPATHY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)		5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic Obstructive Pulmonary Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Julio Menocal		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED APR 23-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIO MENOCAL		22e. ADDRESS 516 TIRAIL AVE - FREDERICK, MD 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/1987		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR APR 06 1987		25b. REGISTRAR'S SIGNATURE Julia Simon-Padua	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached from the death certificate and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then place it in your papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 0 8 3 1 /					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR				
Moey				Virginia	Miller	3 7 87					0115 AM				
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		MONTH March 30, 1914		72		MONTHS	YEARS	HOURS	MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Virginia		U.S.A.				Frederick County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Frederick		Frederick Memorial Hospital		Seamstress		Dry Cleaners									
13a. STATE Maryland 13b. COUNTY Frederick 13c. CITY OR TOWN Frederick 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 21701 100 East Patrick Street															
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST								
John		William	Randolf Kelly Sr.	Leola		E.	Mooney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mr. William E. Miller, Chicago, Ill. 60610		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO		No		217-10-0670											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hypothyroidism															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (he) attended the deceased from 3/6/87 to 3/2/87, 19		19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		3/2/87		19,		19,		19,					
22b. SIGNATURE Austin A. Pearre, Jr.		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/7/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Austin A. Pearre, Jr. MD		22e. ADDRESS 804 Toll House Avenue Frederick, Md. 21701													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 10, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg, Wash., Md. 21783		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR MAR 13 1987		25b. REGISTRAR'S SIGNATURE Julia Dawson-Readers											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then place it in your papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_



## **TO HOSPITAL OR ATTENDING PHYSICIAN.**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death, page 4 must be retained by the hospital or attending physician.

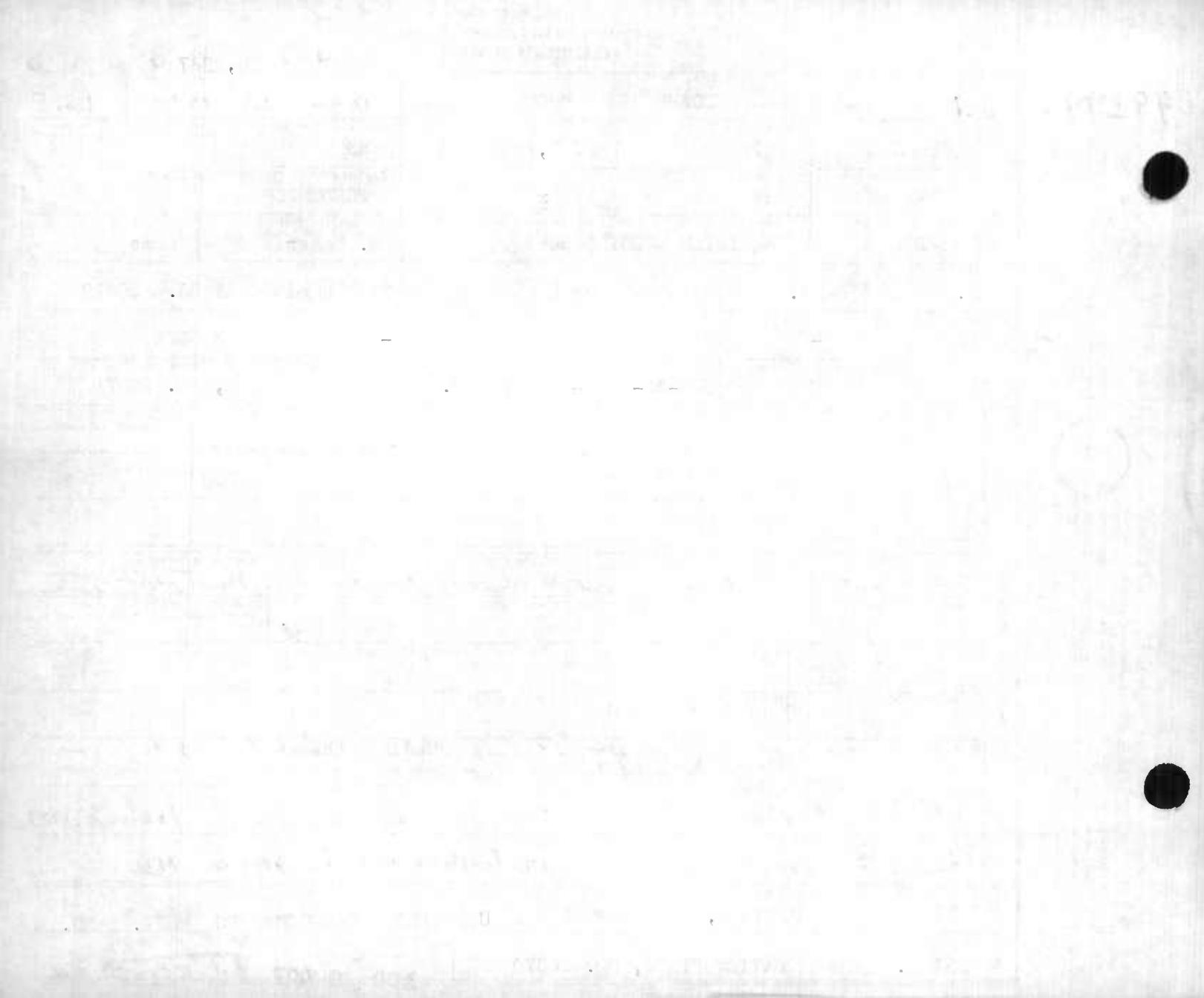
MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRATION

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

MARCH REG. NO. 30, 1987 8 3 8

1. DECEASED NAME (TYPE OR PRINT) <b>MARY DOANE MOORE</b>			2d. DATE OF DEATH MARCH 30 1987	MONTH DAY YEAR	2b. HOUR 1:00 P.M.
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MAY 9, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b>		
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING HOME</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Maker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>Md.</b>	13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Gaithersburg</b>
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>318 Summit Hall Rd. 20879</b>		
14. FATHER'S NAME <b>LEE</b> MIDDLE <b>DOANE</b> LAST			15. MOTHER'S MAIDEN NAME <b>LOUISE</b> MIDDLE <b>SASSER</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>578-26-5756-A</b>		17. INFORMANT <b>LOUISE M. WEST</b>	
24510 BURNT HILL ROAD CLARKSBURG, MD. 20871					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent pulmonary infection, espis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Arteriosclerotic heart disease antecardiac fibrillation, Deltoid muscle, Multiple carious teeth</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 14</u> , 19 <u>1986</u> , to <u>March 30</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Glenn F. Meader Jr</u>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>March 30, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Glenn F. MEADER JR MD</b>		22e. ADDRESS <b>810 Toll House Ave., Frederick, MD</b>			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE <b>APRIL 2, 1987</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>FOREST OAK CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>GAITHERSBURG</b>	COUNTY STATE <b>MONT. MD.</b>
24. FUNERAL DIRECTOR <b>MURIEL H. BARBER</b>		ADDRESS <b>LAYTONSVILLE, MD. 20879</b>	25a. DATE REC'D. BY REGISTRAR <b>APR 9 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Glenn F. Meader Jr</b>



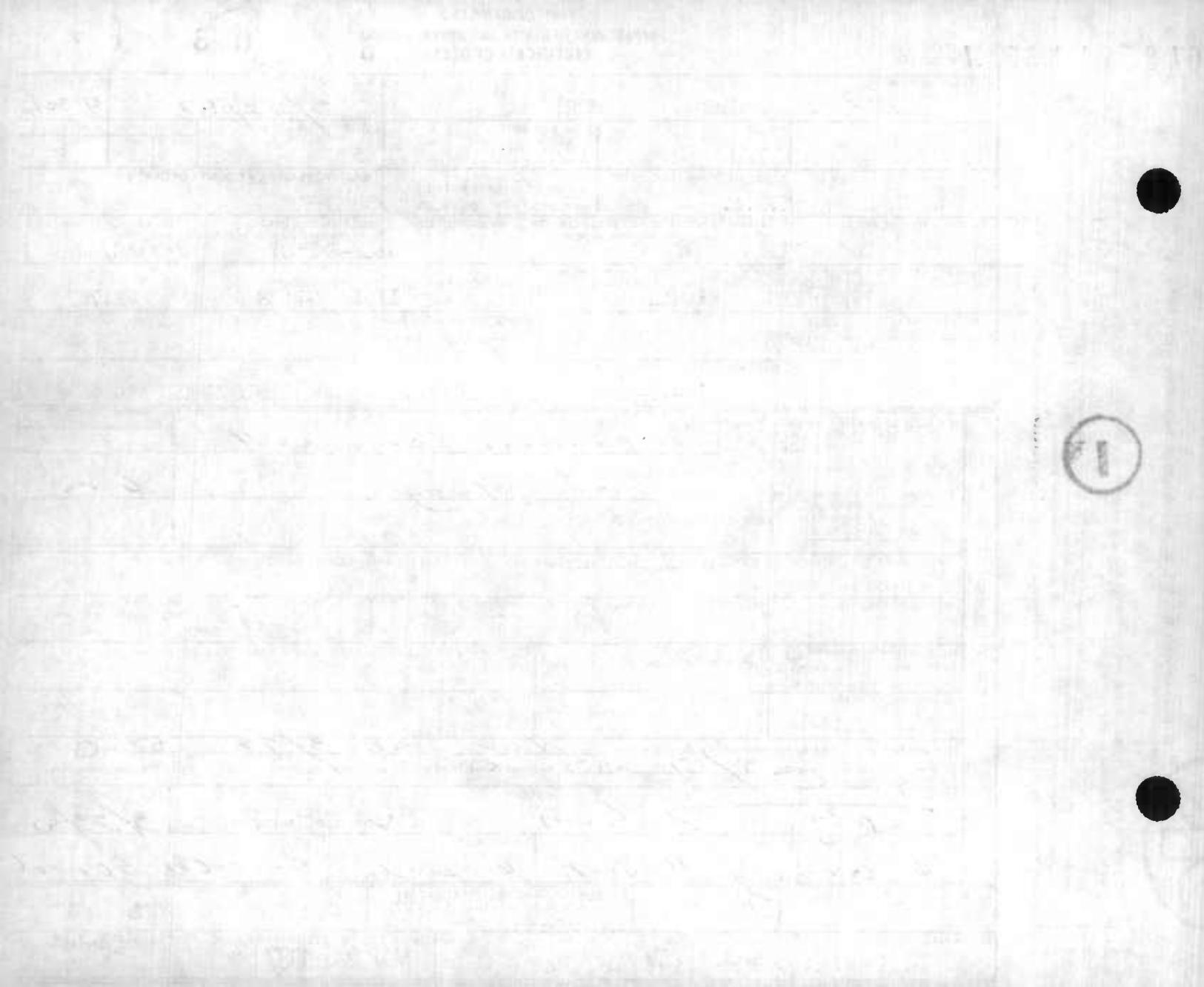
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page and attach pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trauma or death the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108319	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ROBERT			EDWARD	MORT		3/22/87						4:30 P.M.	
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			WHITE	MONTH 12 DAY 28 YEAR 21			65			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MARYLAND			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			FREDERICK				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
KEYMAR			1910 WARNER RD			SELF-EMPLOY			CONTRACTER				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
MD			FREDERICK	KEYMAR		NO <input type="checkbox"/> YES <input type="checkbox"/>			1910 WARNER RD			21757	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
HARRISON WILLIAM MORT						NETTIE EYLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (YES, NO OR UNKNOWN)			17. INFORMANT			ADDRESS				
YES			WII 214-16-1200			C. LOUISE MORT			11910 WARNER RD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>extensive large cell</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DO TO, OR AS A CONSEQUENCE OF (b) <i>long</i>												6 mo	
DO TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>3/17/87</i> to <i>3/17/87</i> , 1987, that (I) (we) last saw the deceased alive on <i>3/17/87</i> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.													
22b. SIGNATURE <i>R.P. Rausch</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/27/87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. George Rausch</i>			22e. ADDRESS <i>4 west 50th Street</i>										
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE <i>03/24/87</i>			23c. NAME OF CEMETERY OR CREMATORIAL SERVICES <i>Carroll Cremation Services</i>			23d. LOCATION <i>Hampstead</i>			CARROLL MD STATE	
24. FUNERAL DIRECTOR NAME <i>D. D. Hartzler</i> ADDRESS <i>New Windsor, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Randall</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed at this time.

## MEDICAL CERTIFICATION

MOSBURY STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 / 08320			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
F. Doris LACKE					Mossburg		3 - 3 - 87		3	3	87	4 15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE		White		MONTH DAY YEAR			52			IF UNDER 24 HRS			
6		7		6 04 34			YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick County,			MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Frederick		Frederick Memorial Hospital		Nurse			Hospital						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/>		1515 Rosemont Ave. 21701					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		Bennett			
Charles				Lackey		Alice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. NEIGHBOR		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		218-30-9369		Mr. Paul W. Mossburg, 1515 Rosemont Ave., Frederick, Md. 21701									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/2/87, 19, to 3/3/87, 19, that (I) (we) last saw the deceased alive on 3/3/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/3/87			
22b. SIGNATURE Austin Barr, Jr.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS							
Dr. Austin Barr, Jr. M.D.		804 Toll House Ave., Fred. Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE OF BURIAL, CREMATION, OR CEMETERY		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
Burial		Mar. 6, 1987 Mt. Olivet Cemetery		Frederick		Frederick		Md.					
24. FUNERAL DIRECTOR Smith Keeney Basford P.A. Funeral Home 106 E. Church St., Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR MAR 09 1987 Julie Jackson-Landark		25b. REGISTRAR'S SIGNATURE									



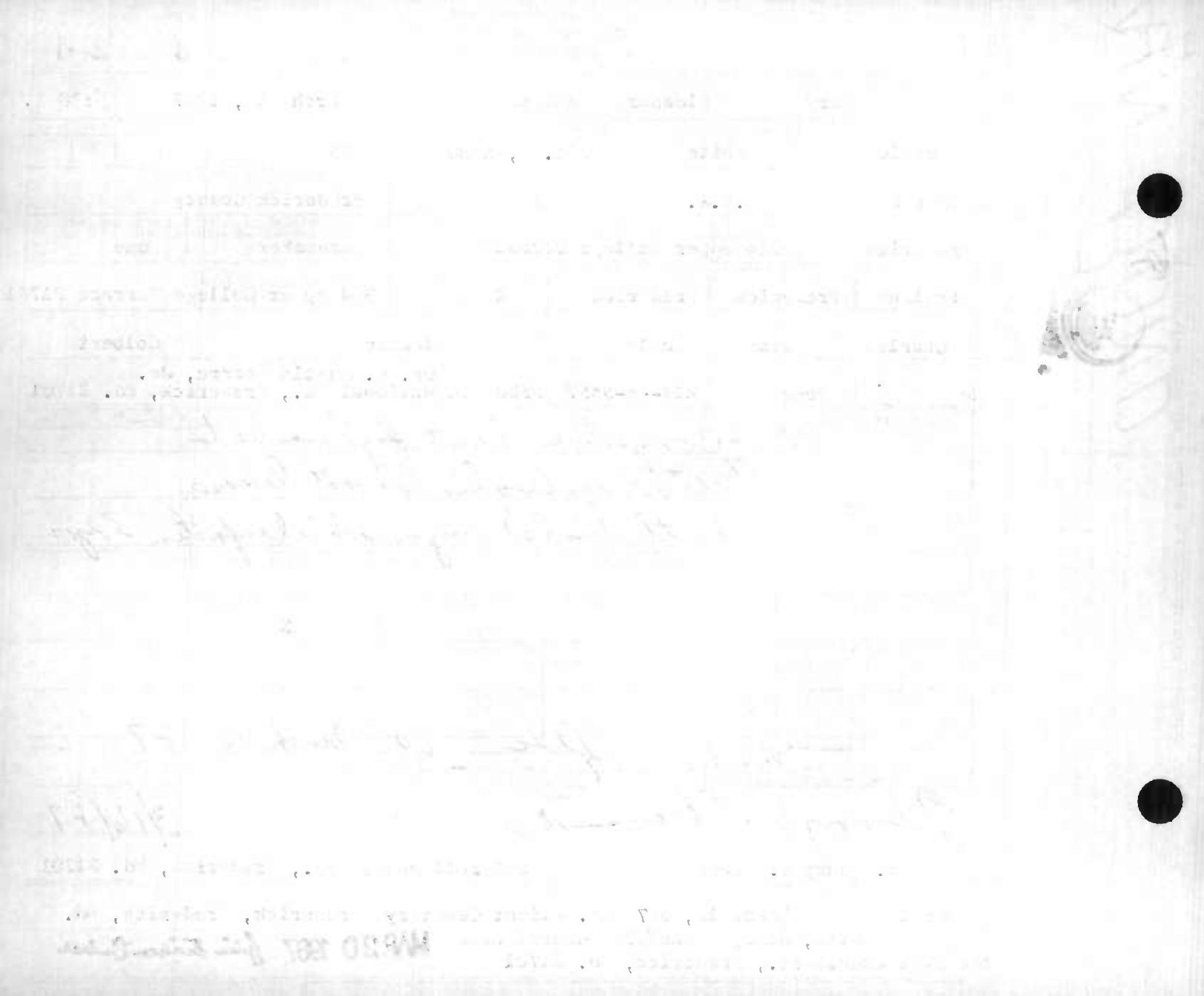
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 / 0 8 3 2 1											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Mary</b>	MIDDLE <b>Eleanor</b>	LAST <b>PEARRE</b>	2a. DATE OF DEATH			MONTH <b>March</b>	DAY <b>16, 1987</b>	YEAR
3 SEX			4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR
<b>Female</b>			<b>White</b>		<b>Sept. 9, 1900</b>			<b>86</b>			<b>5:30 A.M.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisiana</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>304 Upper College Terrace</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>304 Upper College Terrace 21701</b>		
14. FATHER'S NAME FIRST <b>Charles</b>			MIDDLE <b>Dean</b>	LAST <b>Gould</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Eleanor</b>			MIDDLE	LAST <b>Colbert</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Dr. A. Austin Pearre, Jr.			ADDRESS <b>5520 Old National Pk., Frederick, Md. 21701</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure due to</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic heart disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>with healed myocardial infarction 3 yrs</i>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <input checked="" type="checkbox"/> (the) hospital attended the deceased from <b>Dec 19, 60</b> to <b>March 16, 87</b> , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 15, 87</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <b>Henry V. Chase MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/16/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Henry V. Chase</b>			22e. ADDRESS <b>804 Toll House Ave., Frederick, Md. 21701</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>March 17, 1987</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Frederick, Frederick, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>			24b. ADDRESS <b>106 East Church St., Frederick, Md. 21701</b>			24c. REG'D. BY REGISTRAR <b>Jeanne Anderson Lender</b>			24d. REGISTRAR'S SIGNATURE <b>MAR 20 1987</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT:

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 0 8 3 2 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Edna</b>	MIDDLE <b>M.</b>	LAST <b>REESE</b>	2a. DATE OF DEATH MONTH YEAR	March 7, 1987	2b. HOUR 7:30 P.M.	
3. SEX <b>Female</b>			4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE IN YEARS LAST BIRTHDAY	87	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Meridian Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. STREET ADDRESS <b>638 Trail Ave. 21701</b>			
14. FATHER'S NAME FIRST <b>William</b>			MIDDLE <b>D.</b>	LAST <b>Lippis</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Florence</b>			MIDDLE <b>Andrews</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-12-2367</b>			17. INFORMANT ADDRESS <b>Mrs. Wilma Fleming, 3740 Thomas Pt. Rd., Annapolis, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			acute + chronic congestive heart failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDI-VASCULAR DISEASE</b>						
			DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY</b> , 19 <b>69</b> , to <b>MARCH</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>4 MARCH</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George I. Smith</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>March 8, 1987</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. George I. Smith, Jr. MD</b>			22e. ADDRESS <b>804 Toll House Ave., Fred. Md. 21701</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Mar. 10, 1987</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Frederick</b>	COUNTY <b>Frederick</b>	STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>Smith Keeney Basford P.A. Funeral Home</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1987</b>			25b. REGISTRAR'S SIGNATURE <b>John Basford</b>			
106 East Church St., Frederick, Md. 21701									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as being shown any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08323			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
DONALD BLESSING RICE, SR.						March 15, 1987				1:47 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		Caucasian		June 20, 1909		77							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Maryland		USA				Frederick		112 Kline Boulevard		Retired Tire Merchant			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		MD.			
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/>		112 Kline Boulevard 21701					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Walter		Levin		Rice		Bertha		Alice		Dougherty			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			214-10-2476			Mrs. Mary C. Rice			112 Kline Blvd Frederick, Md. 21701				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>extensive small cell carcinoma</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 17, 1987</i> , to <i>Mar 15, 1987</i> , that (I) (we) last saw the deceased alive on <i>Mar 14, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>P. G. Rausch</i>		22c. DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>March 16, 1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				<i>4 West 7th Street, Frederick, Md. 21701</i>							
P. Gregory Rausch, MD PA													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		3/18/87		Mt. Olivet Cemetery		Frederick		Frederick		Maryland			
24. FUNERAL DIRECTOR <i>R. E. Dailey &amp; Son, P.A.</i>		1201 N. Market St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
				Mar 24, 1987		<i>Julia Berger-Rausch</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/tranfer permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "No", show any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08324		
1. FOR STATE REGISTRAR			2. DECEASED NAME FIRST MIDDLE LAST <i>Mary Elizabeth Rice</i>							3a. DATE OF DEATH MONTH DAY YEAR <i>3 8 87</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>09 15 1904</i>			6. AGE (IN YEARS LAST BIRTHDAY) 82 yrs.		7b. HOUR <i>1505M</i>		
7a. BIRTHPLACE STATE OR NATION <i>MD</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH <i>FREDERICK MD</i>				
9. CITY OR TOWN OF DEATH <i>FREDERICK</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FREDERICK MEMORIAL HOSPITAL</i>		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) <i>HOUSEWIFE</i>			13b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION: 13b. STATE <i>MD</i>			13b. COUNTY <i>FREDERICK</i>		13c. CITY OR TOWN <i>THURMONT</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6610 Mountaintale Rd., 21788</i>		
14. FATHER'S NAME <i>SAMUEL COLEMAN EATON</i>					15. MOTHER'S MAIDEN NAME <i>GRACE ELIZABETH RICE</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>NO</i>			16b. SOCIAL SECURITY NO <i>N/A</i>		17. INFORMANT <i>William C. Rice, Jr.</i>			18. ADDRESS <i>Blue Ridge Summit, PA</i>				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>(Grand Vesicle) Accidental (Thrombosis)</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>t</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 20, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <i>AS WORK</i> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>318187</i>		21f. LOCATION STREET <i>318187</i> CITY OR TOWN <i>318187</i> COUNTY <i>318187</i> STATE <i>318187</i>							
22a. I certify that (i) (this hospital) attended the deceased from <i>318187</i> 19 to <i>318187</i> 19, that (ii) (we) last saw the deceased alive on <i>318187</i> 19, and that in my (our) opinion death occurred on the date and hour and from the cause stated above. (If we did not view the body after death, check here) <input type="checkbox"/>												
22b. SIGNATURE <i>Robert L. Kaufmann, MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22d. DATE SIGNED <i>3/9/87</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT L. KAUFMANN</i>			22f. ADDRESS <i>804 Tollhouse Ave., Frederick, MD 21701</i>									
23a. BURIAL, CREMATION, REMOVAL BURIAL <i>3/12/87</i>			23b. DATE <i>3/12/87</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Lewistown Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Lewistown</i> COUNTY <i>Frederick</i> STATE <i>MD</i>				
24. FUNERAL DIRECTOR NAME <i>G. DOUGLAS STAUFFER</i> ADDRESS <i>1621 Opossumtown Pike, Frederick, MD 21701</i>										25a. DATE REC'D. BY REGISTRAR <i>MAR 12 1987</i>		
25b. REGISTRAR'S SIGNATURE <i>John Burton-Baudier</i>												

filed S.I. 1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PW 1 SIGNATURE, FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
0 8 3 2 5 REG. NO.											4:30A								
1 - STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST NAOMI			MIDDLE HARRIET			LAST RICE			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH APR	DAY 18	YEAR 1987	2b. HOUR 4:30A
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9c. DATE PRONOUNCED DEAD		MONTH APR	DAY 18	YEAR 1987	2d. HOUR 8:00A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick,									
10. CITY OR TOWN OF DEATH Mountaintdale			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10223 Bethel Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY NONE							
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Mountaintdale			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 10223 Bethel Road, 21701								
14. FATHER'S NAME FIRST SAMUEL			MIDDLE D.			LAST SHIRLEY			15. MOTHER'S MAIDEN NAME FIRST SARAH		MIDDLE JANE			LAST DURY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NONE			16c. ADDRESS 10313 BETHEL RD. FREDERICK, MD. 21701			17. INFORMANT LESTER RICE										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Robert J. Thomas</i>												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> TITLE (SPECIFY) M.D. <i>Robert J. Thomas</i> , MEDICAL EXAMINER			and in my opinion				
EXAMINER'S NAME (TYPE OR PRINT) R. J. Thomas, MD			ADDRESS 812 Toll House Ave. Frederick, Md.									DATE SIGNED 3-18-87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 21, 1987			23c. NAME OF CEMETERY OR CREMATORIAL BLUE RIDGE CEMETERY			23d. LOCATION THURMONT			COUNTRY FREDERICK MARYLAND							
24. FUNERAL DIRECTION NAME <i>R. E. Dailey &amp; Son, P.A.</i>			ADDRESS 615 E. Main St., Thurmont, Md. 21788			25a. DATE REC'D. BY REGISTRAR APR - 2 1987			25b. REGISTRAR'S SIGNATURE <i>John Davidson, Landau</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my best.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked as "Yes" in Part 1B, then any injury, or other traumatic event, that occurred during the time of death, should be detailed for use as the burial permit. Then please remove the stamp from the State Dept. of Health and Mental Hygiene prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 08320							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Irene			MIDDLE IVY			LAST Ricketts			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR March 10, 87 2145 M	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			June 3, 1926			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD										
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife			12b. KIND OF BUSINESS OR INDUSTRY Home										
13a. STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Taneytown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4795 Feeser Rd. / 21787							
14. FATHER'S NAME Wilson			MIDDLE -			LAST Wood			15. MOTHER'S MAIDEN NAME FIRST Lenora			MIDDLE -			LAST Belle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-82-5187			17. INFORMANT James W. Ricketts, Jr.			ADDRESS 4795 Feeser Rd. Taneytown, Md. 21787										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive b.p. bleeding												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo							
DUE TO, OR AS A CONSEQUENCE OF (b) Gastric adeno carcinoma																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF (c) multiple myeloma																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a cardiac failure																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> , 19 <u>87</u> , to <u>3/10</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>3/10</u> , 19 <u>87</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>3/10/87</u>							
22d. SIGNATURE <u>RJ</u>			22e. DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>										
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS			Frederick Memorial Hospital/Frederick, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 14, 87			23c. NAME OF CEMETERY OR CREMATORIAL Grace United Church			23d. LOCATION CITY OR TOWN Taneytown, Carroll, Maryland										
24. FUNERAL DIRECTOR NAME Skiles funeral home / 136 E. Baltimore St. Taneytown, Md.			25a. DATE REC'D. BY REGISTRAR MAR 17 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Deaderick</u>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

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retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove pages 1 and 2 and be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign below.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03321		
1. DECEASED NAME (TYPE OR PRINT)			2d. DATE OF DEATH		2b. HOUR		
Marvin Lester Ridgely, Sr.			3 24 87		5:40 PM		
3 SEX		4. RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		
Male		White	MONTH	DAY	YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Frederick County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Frederick		Frederick Memorial Hospital				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4737 A Mill Bottom Rd. 21771	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST
George		W.	Runkles	Eliza		Evely	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		216-01-1523		Marvin L. Ridgely, Jr.		21240 New Hampshire Ave. Brookeville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia was shock and, besides</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>septicemia</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hypertension, Chronic renal insufficiency, Atherosclerotic cardiovascular disease, Diabetes</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>the deceased was struck and, besides</i>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. LOCATION STREET	
22a. I certify that (I) (the hospital) attended the deceased from <i>3-21-87</i> to <i>3-26-87</i> , that (I) (we) last saw the deceased alive on <i>3-23-87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur G. Novak, M.D.</i> DEGREE							
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>3/24/87</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur G. Novak, M.D.</i>		22e. ADDRESS <i>187 Horns Johnson Dr. Frederick, Md. 21701</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 26, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Prospect		23d. LOCATION CITY OR TOWN Mt. Airy, Frederick, Md.	
24. FUNERAL DIRECTOR NAME <i>Olin L. Molesworth, P.A., Damascus, Md.</i> ADDRESS							
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 27 1987</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03328

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>WESLEY</i>	MIDDLE <i>Poole</i>	LAST <i>ROBERTSON</i>	2a. DATE OF DEATH	MONTH <i>March</i>	DAY <i>14</i>	YEAR <i>1987</i>	2b. HOUR <i>11:27 AM</i>										
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <i>July 23, 1919</i>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co., MD.</b>											
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Grain Elevator Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Mt. Airy</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>4840 Ridge Road, 21771</b>								
14. FATHER'S NAME FIRST <b>Paul</b>			MIDDLE <b>E.</b>			LAST <b>Robertson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elsie</b>			MIDDLE <b>Ann</b>			LAST <b>Duvall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>			16c. 212-12-2601			17. INFORMANT <b>P. Marie Robertson, Same as # 13</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro vascular accident</i>																				
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) } DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hypertension, coronary artery disease</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>3-14</i> , 19 <i>83</i> , to <i>3-14</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>3-14</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Kusay Barakat</i>															DEGREE <i>MS</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kusay BARAKAT</i>			22e. ADDRESS <i>335 Park Avenue Frederick MD 21701</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>3-17-1987</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Stone Chapel</i>			23d. LOCATION CITY OR TOWN			COUNTY STATE <i>Carroll, Md.</i>								
24. FUNERAL DIRECTOR <i>Charles W. Burrier, Jr., Sykesville, Md.</i>															25a. DATE REC'D. BY REGISTRAR <i>MAR 19 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Jordan Radue</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08329			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Ava Marie RUBY						March 7, 1987					1:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		May 18, 1969		17 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Frederick County, MD.					
Virginia		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Monrovia		11794 Ridgeway Ct.		none									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Maryland		Frederick	Monrovia			11794 Ridgeway Ct. 21770							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	Balsinger						
Roger		Lee	Ruby	Ruth									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		8656 Piney Branch Rd.							
No		219-08-6807		Roger Lee Ruby,		Silver Spring, Md. 20901							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Artery Thrombosis</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>End-stage lymphangiomatous with Autonomic Nervous System</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-28, 19-87 to 3-7, 19-87, that (I) (we) last saw the deceased alive on 3-3, 19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Arthur G. Manalo</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur G. Manalo, M.D.		22e. ADDRESS Green Valley Shopping Center, Monrovia, Md.				22c. DATE SIGNED Mar. 7, 1987							
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE Burial Mar. 10, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove		23d. LOCATION Mt. Airy, Carroll, Md.		CITY OR TOWN		COUNTY STATE			
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAR 19 1987		25b. REGISTRAR'S SIGNATURE <i>Olin L. Molesworth, P.A.</i>					

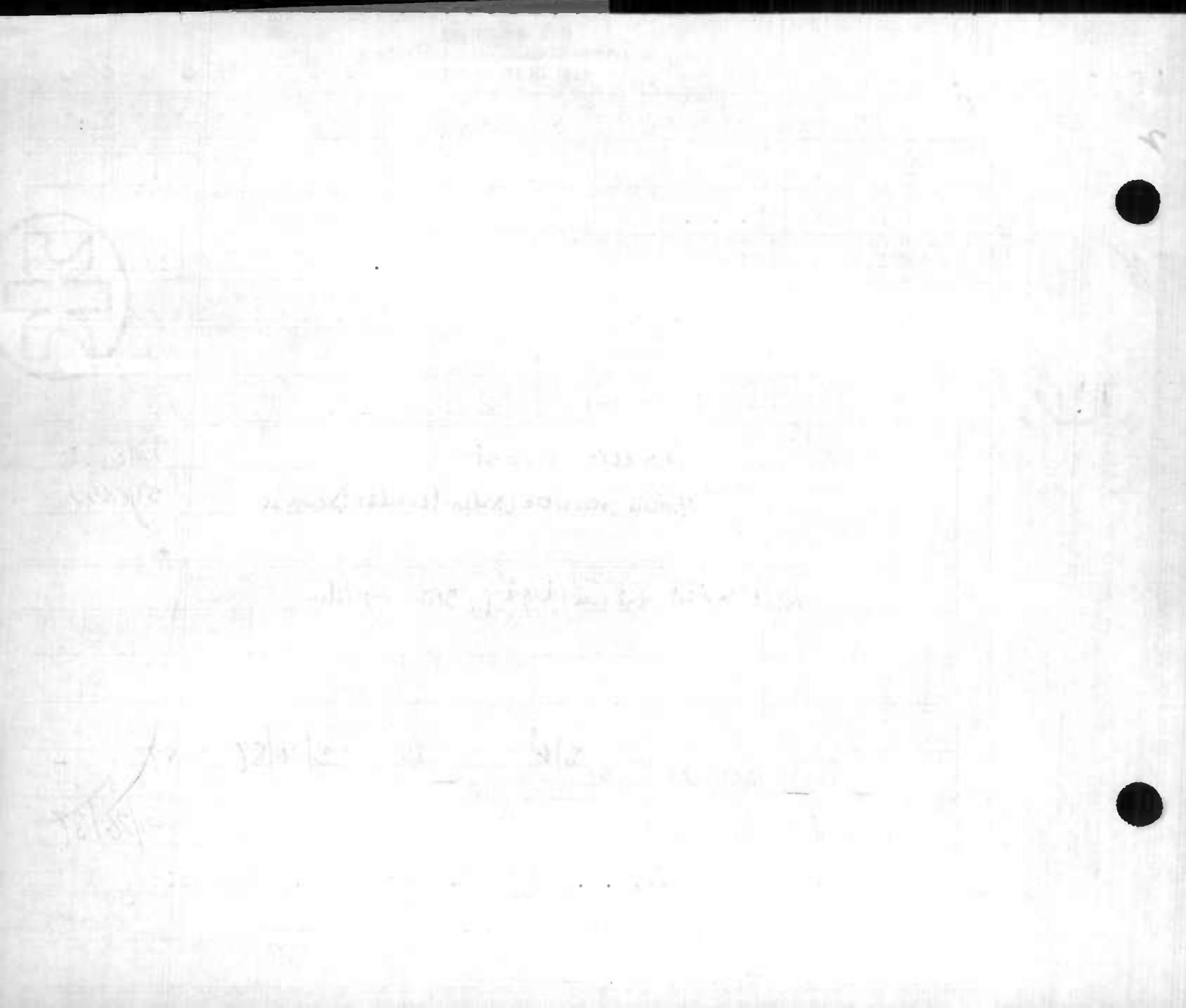
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the Burial-Transit Permit. Then please remove carbon paper. Page 1 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, in the medical examiner's report, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108330							
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR										
1. DECEASED NAME (TYPE OR PRINT)			Vernon Crawford Scarborough			3-26-1987			11:10AM										
3 SEX		4. RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.												
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist			12b. KIND OF BUSINESS OR INDUSTRY Civil Service												
13 STATE Maryland		14 COUNTY Baltimore		13c CITY OR TOWN Relay			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 1829 Clark Boulevard, 21227									
14 FATHER'S NAME Frederick		MIDDLE FIRST Scarborough		15 MOTHER'S MAIDEN NAME Anna			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No			16b SOCIAL SECURITY NO 037-01-1052			17 INFORMANT Lynn S. Siegel, 708 Midway Drive						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteria arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 minute							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic Cardio-vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												5 years							
DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: o <u>Left sided hemiplegia; optic neuritis</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN LINE PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>March 26 1987</u> , and that in (my) ( <u>    </u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>    </u> ) did ( <u>    </u> ) view the body after death.												22b. DATE SIGNED 3/26/87							
22b. SIGNATURE <u>Bernard O. Thomas Jr.</u>												22c. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard O. Thomas, Jr., M.D.												22e. ADDRESS 228 N. Market St., Frederick, MD 21701							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3/30/87			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore			23e. STATE Maryland							
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.												25a. DATE REC'D. BY REGISTRAR MAR 30 1987			25b. REGISTRAR'S SIGNATURE				
ADDRESS 21229																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 08331
1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR		
1. DECEASED NAME (TYPE OR PRINT)		DIANA JOAN SHUPE		3 28 87 9:37 P.M.		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR		
				Aug. 15, 1943		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Frederick		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick		
13a STATE Maryland		11a CITY OR TOWN Carroll		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Richard		12a MIDDLE F.		13e STREET ADDRESS / ZIP CODE 6782 Runkles Road 21771		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 216-40-6013A		17 INFORMANT Robt. V. Shupe(husband) same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INFARCTION MI						
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA						
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 3-28-1987 to 3-28-1987, that (we) (I) (we) last saw the deceased alive on 3-28-1987, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (we) did (did not) view the body after death.						
22b. SIGNATURE S. Kahan		DEGREE MD		22c DATE SIGNED 3-28-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. KAHAN MD		22e ADDRESS 4 W 7th ST		21701 Frederick, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/87		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park		
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				23d. LOCATION CITY OR TOWN Rockville, Maryland COUNTY STATE		
				25a. DATE REC'D. BY REGISTRAR APR - 2 1987		
				25b. REGISTRAR'S SIGNATURE John A. [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and send it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, which may have caused death, attach a separate sheet and mail to the State Department of Health and Mental Hygiene.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8408332
1. DECEASED NAME (TYPE OR PRINT) <b>NAPOLEON TELESPHONE SIROIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 25 87</b>	2b. HOUR <b>5:15 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 05 07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CANADA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK, MD.</b>		
10. CITY OR TOWN OF DEATH <b>NEW MIDWAY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11250 HILL ROAD</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COOK</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>FREDERICK</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>800 MOTTER AVE. / 21701</b>	
14. FATHER'S NAME FIRST <b>FELIX</b>	MIDDLE <b>GEORGE</b>	LAST <b>SIROIS</b>	15. MOTHER'S MAIDEN NAME FIRST <b>CATHERINE</b>	MIDDLE LAST <b>MARTIN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 046-10-5696</b>	17. INFORMANT <b>Mrs. Thelma Furr</b>	ADDRESS <b>11250 Hill Rd. New Mdway</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Neoplastic Colon cancer - Terminal</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>3-12 187</i>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-22 1986</i> , to <i>3-25 1987</i> , that (I) (we) last saw the deceased alive on <i>3-12 187</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Arthur G. Manalo.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. DATE SIGNED <i>3/25/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur G. Manalo, M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3/27/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>UTICA CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>UTICA</b>	23e. COUNTY <b>FREDERICK</b>	STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <i>Robert E. Dailey &amp; Son PA</i>	ADDRESS <b>1201 N. Market Frederick, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>APR 3 1987</b>	25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Kendall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and printed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Please attach this certificate to the burial permit and file within 72 hours after death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108333						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 3 22 87									2b. HOUR 0035 M						
1. DECEASED NAME (TYPE OR PRINT) <i>EVAED Clinton Jack Smith</i>			FIRST MIDDLE "Jack <sup>INST</sup> Smith			5. DATE OF BIRTH MONTH DAY YEAR Apr. 11 1911			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS									
3. SEX Male			4. RACE White			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.						
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital									12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY Asst. Manager Food Chain						
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 414 Burke Street 21701						
14. FATHER'S NAME FIRST George MIDDLE H. LAST Smith			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Remsberg															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes National Guard			16b. SOCIAL SECURITY NO. 214-10-2592			17. INFORMANT Mrs. Lauretta M. Smith, 414 Burke St., Frederick, Maryland 21701												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>End stage COPD</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible lung cancer</i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>chronic heart Prostatic cancer</i>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <i>Mar 12, 1987</i> to <i>Mar 12, 1987</i> , that (I) (we) last saw the deceased alive on <i>Mar 12, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <i>Ed Hansen</i>			DEGREE		22c. DATE SIGNED <i>3/14/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ed Hansen</i>			22e. ADDRESS <i>1475 Farm Ave. Frederick Md.</i>									ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Mar 25, 1987</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Resthaven Mem. Gardens</i>			23d. LOCATION CITY OR TOWN <i>Frederick Frederick Md.</i>									
24. FUNERAL DIRECTOR <i>Smith Keeney Basford Funeral Home</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1987</i>									25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Lundquist</i>						
106 East Church St., Frederick, Md. 217																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **D** item 18 shows any injury, or other traumatic event, the medical certification must be filed within 72 hours after death. Page 4 may be filed within 72 hours after death. Page 3 in by the funeral director, page 3

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 08334	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ray Snyder SMITH						March 27, 1987						2:05 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White		Nov. 5, 1921		65			MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick County, MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Frederick			Frederick Memorial Hospital		Printer		Newspaper						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		ZIP CODE		
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			108 West Fifth Street,		21701		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
Elmer					Smith	Fannie			Catherine	Shryock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			ADDRESS					
No			None		Dwight V. Smith,			440 Carrollton Drive					
			217-18-8421					Frederick, Md. 21701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few mts.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Arterio vascular disease</i> <i>Hypertension</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) -							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>4/4/87</i> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.			11 31 1977			11 31 1977			31 27 1987				
22b. SIGNATURE <i>S. Majeed</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/30/87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Majeed, M.D.			22e. ADDRESS 4 East Church Street, Frederick, Md. 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial March 30, 1987			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery			23d. LOCATION CITY OR TOWN Utica, Frederick Co., Maryland				
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701									25a. DATE REC'D. BY REGISTRAR APR 01 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

4/10

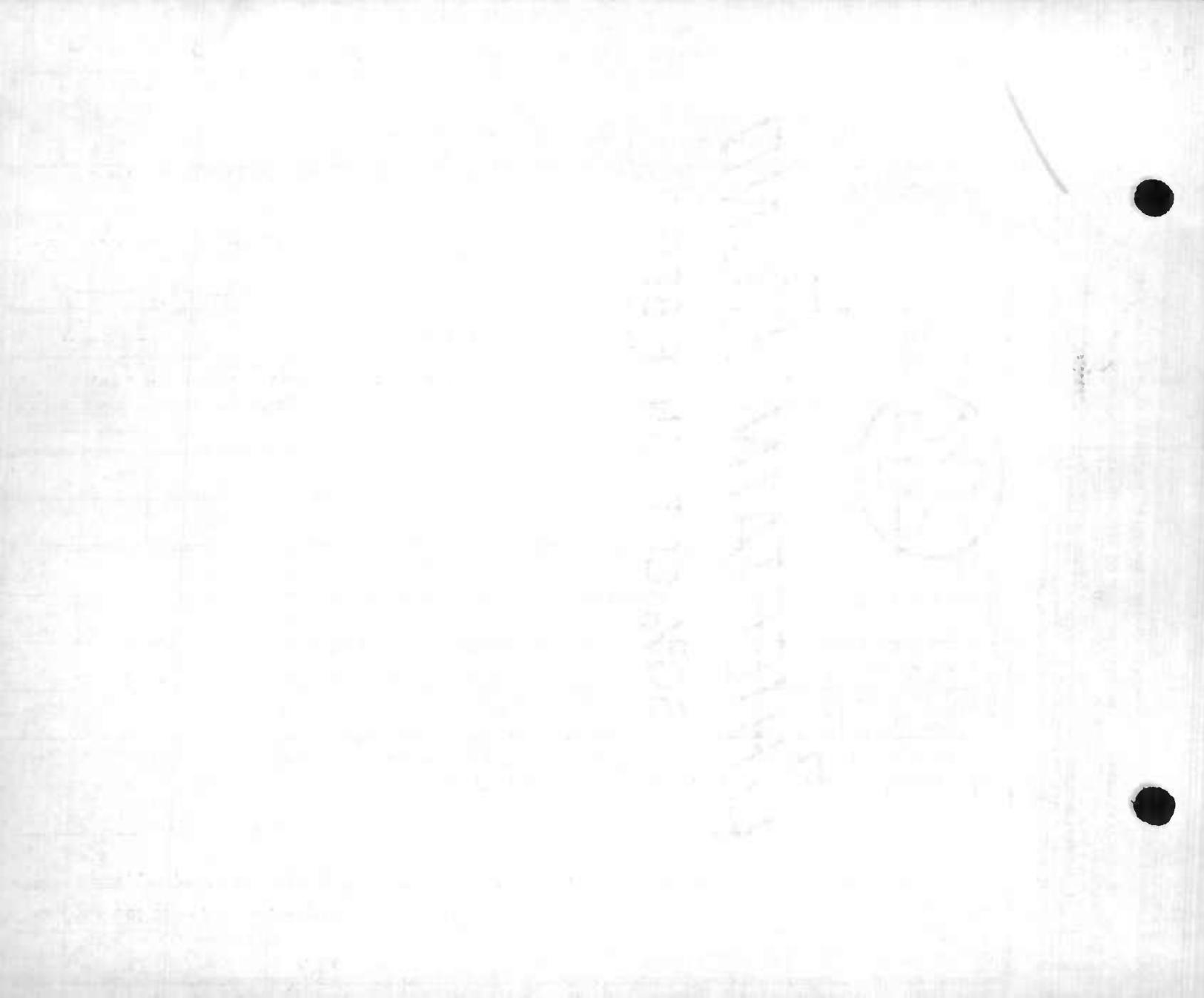


4/10 1891 0994

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08335

1.- STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR	2b. HOUR	
		Kenneth W. Stine						3 19 1987	M	
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY) 39 YRS	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS		2c. DATE PRONOUNCED DEAD 3 19 1987	2d. HOUR 9 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County				
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Fabric Mfgr.		
13a. STATE Penna.		13b. COUNTY Schuylkill		13c. CITY OR TOWN Sch. Haven	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 314 St. Peters St. 17972				
14. FATHER'S NAME FIRST William		MIDDLE D.	LAST Stine	15. MOTHER'S MAIDEN NAME FIRST Vivian			MIDDLE LAST Kerschner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 181-36-8665			17. INFORMANT Judith Stine (Wife)			ADDRESS (Same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  8160 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <b>XXX</b> MONTH DAY YEAR 6:30 P.M. 3 19 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of tractor-trailer out of control					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 270			CITY OR TOWN	COUNTY Frederick, MD STATE MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED 3/20/87
ACTUAL SIGNATURE <i>William M. Zane, M.D.</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		ADDRESS 111 Penn St. Balto. MD..								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/1987		23c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery			23d. LOCATION CITY OR TOWN W. Brunswick			STATE Schuylkill Co. Pa.
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Dundalk Md. 21222		25a. DATE REC'D. BY REGISTRAR MAR 23 1987			25b. REGISTRAR'S SIGNATURE <i>Leighden Pendleton</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return both parts. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, a medical examiner must be notified before the death certificate is filed.

048899 APR 1 1987

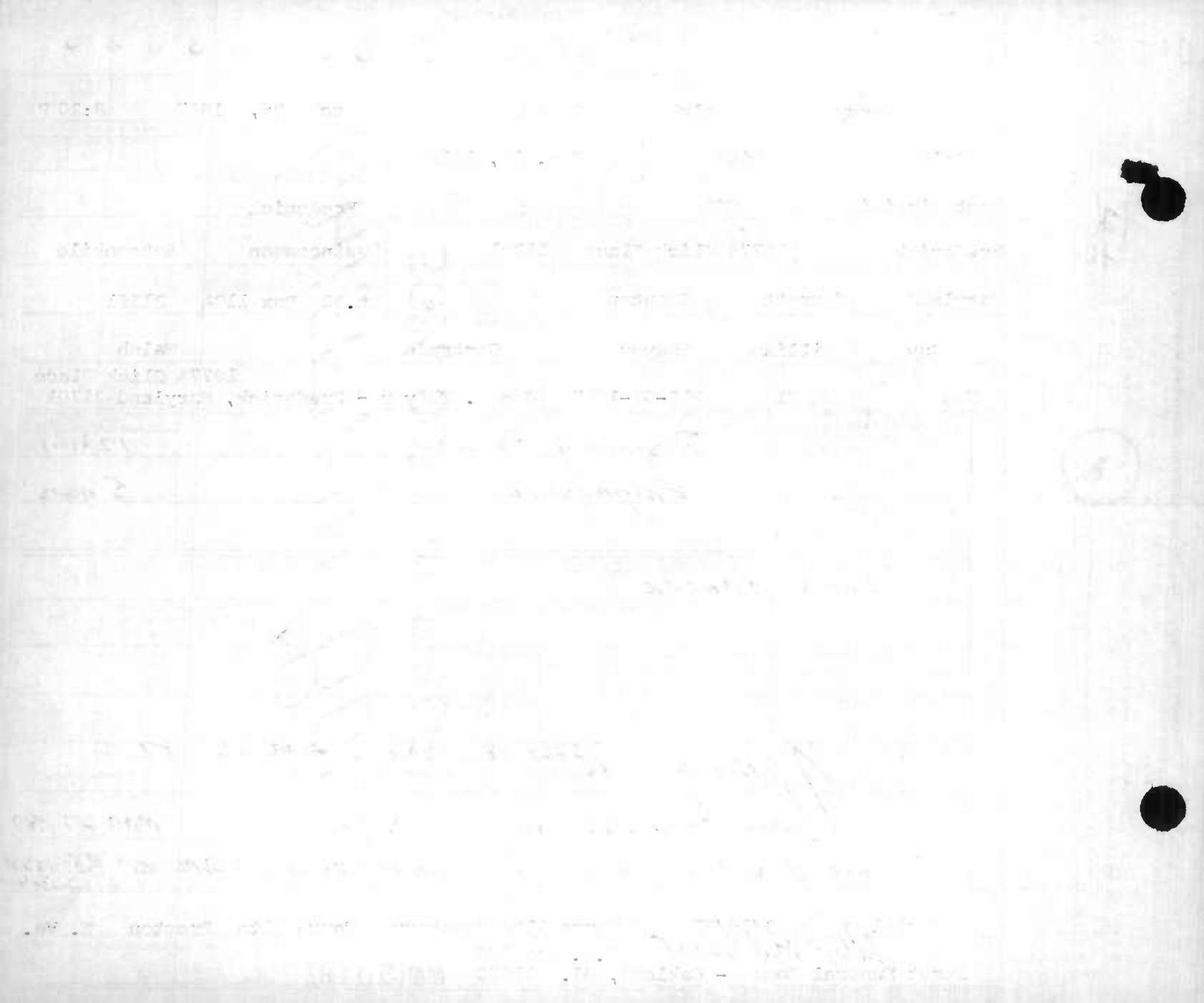
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8708336

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Percy</b>	MIDDLE <b>Walsh</b>	LAST <b>THAYER</b>	2a. DATE OF DEATH <b>March 26, 1987</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>8:20 P M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 18, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b>		MD.				
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1877A Glick Place 21701</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Businessman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Swanton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 2 Box 112A 21561</b>				
14. FATHER'S NAME FIRST <b>Guy</b>		MIDDLE <b>William</b>		LAST <b>Thayer</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b>		MIDDLE		LAST <b>Walsh</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 213-03-1927</b>		17. INFORMANT <b>Jon E. Thayer - Frederick, Maryland 21701</b>		ADDRESS <b>1877A Glick Place</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c)												
5 years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>LUNG cancer</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) saw the deceased alive on <b>Nov 12 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. SIGNATURE <b>Thomas E. Walsh MD</b>		22b. DEGREE				22c. DATE SIGNED <b>Mar. 27 1987</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas E. Walsh MD</b>		22e. ADDRESS <b>PULMONARY CLINIC, NAVAL HOSP, BETHESDA, MD 20814</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/30/87</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Terra Alta Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Terra Alta Preston W. Va.</b>						
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home</b>		ADDRESS <b>P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Jeanne Fidler</b>						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08331

1. DECEASED NAME (TYPE OR PRINT)			FIRST Herman	MIDDLE Andrew	LAST Thomas	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	MONTH 3	DAY 7	YEAR 1987	2b. HOUR 12:30							
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08-27-1949	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD 3/7/1987	MONTH 3	DAY 7	YEAR 1987	a.m.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.											
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction worker			12b. KIND OF BUSINESS OR INDUSTRY contracting								
13a. STATE MD	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 E. Third Street/21701												
14. FATHER'S NAME FIRST George J. Thomas Sr.			15. MOTHER'S MAIDEN NAME FIRST Alice L. Bryant														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. Viet Nam 217-54-6262			17. INFORMANT Mr. & Mrs. George J. Thomas-Cumberland, MD			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3/7/1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell at construction site		STREET					CITY OR TOWN		COUNTY		STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) construction site		21f. LOCATION Court & Patrick Sts. Frederick, Frederick Co													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Incident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Charles P. Kokes, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 3/7/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03-11-1987		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE MD							
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS James F. Scarpelli, Cumberland, MD 21502												25a. DATE REC'D. BY REGISTRAR MAR 11 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pondell			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8708358
1 - FOR STATE REGISTRAR		1c. DECEASED NAME FAMILY (TYPE OR PRINT) ROLAND McDONALD THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR 03 09 1987
3 SEX MALE		4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 03 05 1917	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	2b HOUR M
7a BIRTHPLACE MD		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD.	
10. CITY OR TOWN OF DEATH FREDERICK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITER/KIT.MGR
13a STATE MD		13b COUNTY FREDERICK	13c CITY OR TOWN FREDERICK	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 416 Burke St., 21701
14 FATHER'S NAME BENJAMEN		MIDDLE THOMPSON	LAST OSSIE	FIRST MIDDLE LAST YOUNG	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. N/A	17 INFORMANT Alberta L. Thompson	ADDRESS Frederick, MD 416 Burke St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture thoracic aortic Aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Gastric ulcer</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 3</u> , 19 <u>61</u> , to <u>March 9</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Bernard O. Thomas Jr.</i>		DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD O. THOMAS, JR.		22e. ADDRESS 228 N. Market St., Frederick, MD 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/12/87	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	23d. LOCATION CITY OR TOWN Frederick	COUNTY Frederick STATE MD
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR MAR 12 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Johnson</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8708339
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>Millard</i>	MIDDLE <i>Richard</i>	LAST <i>WACHTER JR</i>	2a. DATE OF DEATH MONTH DAY YEAR 3/28/87
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 22, 1916 YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	2b. HOUR 0222x
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.	
10. CITY OR TOWN OF DEATH <i>Frederick</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Frederick Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Frederick</i>	13c. CITY OR TOWN <i>Frederick</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14. STREET ADDRESS, ZIP CODE 216 West Fifth Street, 21701
14. FATHER'S NAME FIRST <i>Millard</i>	MIDDLE <i>R.</i>	LAST <i>Wachter, Sr.</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Jennifer</i>	MIDDLE LAST <i>Irene Rice</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN <i>Yes</i>	16b. SOCIAL SECURITY NO. W. W. II	17. INFORMANT Mrs. Dolyne L. Wachter,	ADDRESS 216 West Fifth Street Frederick, Md. 21701	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>multiple myocardial infarctions</i> DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>coronary artery disease</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 or PART 2) saw the deceased alive on 3/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22. Identify that (I) (this hospital) attended the deceased from 3/28 19 87, to 3/28 19 87, that (I) (we) lost saw the deceased alive on 3/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>John A. Vitarello, M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. John A. Vitarello, M.D.</i>	22e. ADDRESS 335 Park Ave., Frederick, Maryland 21701	22f. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE Mar 31, 1987	23c. NAME OF CEMETERY OR CREMATORIAL RESTHAVEN MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN Frederick, Md.	23e. DATE REC'D. BY REGISTRAR APR 01 1987
24. FUNERAL DIRECTOR <i>Richard C. Safer</i> Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	23b. REGISTRAR'S SIGNATURE <i>Julia Gordon Radke</i>			
BP _____				
DHMH - 16 60M 7/84 (VRA 15, 4)				

4110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed in by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be detached and filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 / 08340

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
STELLA Georgia WANTZ						3-12-87				7:55 A M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		6-7-1906		80		MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA						Frederick County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Frederick		Citizens Nursing Home				Cleaning		21727					
13a. STATE Maryland						13b. COUNTY Frederick		13c. CITY OR TOWN Emmitsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10354 Harney Road	
14. FATHER'S NAME Charles Edward Ridge								15. MOTHER'S MAIDEN NAME Stella Virginia Knott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS 213-16-1800		17. INFORMANT Charles L. Wantz, Jr., 10354 Harney Rd.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO OR AS A CONSEQUENCE OF (b) <i>Chronic Myeloid leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Schizophrenia with Tardive Dyskinesia</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Schizophrenia with Tardive Dyskinesia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>March 11 1987</i> to <i>March 12 1987</i> , that (I) last saw the deceased alive on <i>March 11 1987</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Bernard O. Thomas</i>						DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>3/12/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. O. Thomas, Jr.						22e. ADDRESS 228 North Market St., Frederick, Md. 21701							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE				
Burial		16 March 87		Elias Lutheran Church		Emmitsburg		Frederick	MD				
24. FUNERAL DIRECTOR NAME <i>Skiles Funeral Home</i>						ADDRESS Emmitsburg, MD 21727							
DHMH - 16 60M 7/84 (VRA 15, 4)						25. DATE REC'D. BY REGISTRAR MAR 19 1987				26. REGISTRAR'S SIGNATURE <i>Julie Gordon-Randee</i>			

1982 0 19A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 / 0 8 3 4 1		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
04707 MR 1307 MINNIE			ELLEN		WEAST		03 06		1987		8:25 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		05 28 1889			97			IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK			MD.		
10 CITY OR TOWN OF DEATH FREDERICK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOME FOR THE AGED		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXAMINER			12b. KIND OF BUSINESS OR INDUSTRY INSURANCE					
13a STATE MD		13b COUNTY FREDERICK		13c CITY OR TOWN FREDERICK		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 115 Record St., 21701				
14 FATHER'S NAME JOHN		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME ANNIE		MIDDLE	LAST			NOTNAGLE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) N/A		16b SOCIAL SECURITY NO 160-10-4268		17 INFORMANT Bonnie Huffman		ADDRESS Myersville, MD 3005 Meadowhill Dr.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Gastrintestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Gastritis</u> 6 hours. 6 days.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <u>June 1</u> , 19 <u>85</u> , to <u>Present</u> , 19 <u>87</u> , that (II) <input type="checkbox"/> lost saw the deceased alive on <u>3/8</u> , 19 <u>87</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (III) <input type="checkbox"/> (I did not) view the body after death.												
22b. SIGNATURE <u>LeRoy T. Davis</u>		22c. DEGREE <u>M.D.</u>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 801 Toll House Ave., Frederick, MD 21701		22f. DATE SIGNED <u>3/6/87</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 3/7/87		23c NAME OF CEMETERY OR CREMATORIAL Resthaven Crematory		23d LOCATION CITY OR TOWN Frederick		COUNTY	STATE			
24 FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR MAR 12 1987		25b. REGISTRAR'S SIGNATURE <u>John T. Davis, Jr.</u>								
DHMH - 16 60M 7/84 (VRA 15, 4)												

100% COTTON TERRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 / 0 8 3 4 2											REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Franklin				Eugene	Weller	3			7	87	1910			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			White	MONTH	DAY	YEAR	52			MONTHS	DAYS	IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			U.S.A.						Frederick County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Auto Mechanic			Car Dealer					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Frederick			Monrovia						4424 Green Valley Rd., 21770		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			Roy	Lawson	Weller				Frances	Doris	McDonough			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			None			Mrs. Shirley A. Weller			4424 Green Valley Rd., Monrovia, Md. 21770					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Pulmonary embolus 9289												6 Hours		
DUE TO, OR AS A CONSEQUENCE OF (b) Bacterial meningitis												6 Days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
Renal failure, ileus			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19a. DATE OF OPERATION 3/4/87			Intracerebral hematoma			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/17/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.			3/21/87 19 87 10			3/7 19 87								
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
M Raphaelson MD			MD									3/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. BURIAL, CREMATION, REMOVAL (SPECIFY)			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
M Raphaelson MD			400 7th St Frederick, Md. 21701			Burial			Mt. Olivet Cemetery			Frederick, Frederick, Md.		
24. FUNERAL DIRECTOR'S NAME 106 East Church St., Frederick, Md. 21701			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John Dearden						MAR 11 1987			John Dearden					

views, software

English

before you leave town

million dollars

in cash

you're not going to need this

any more

but it's

important to know where

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traffic lights

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed while 24 hours after death. Page 4 may be completed and filed in by the funeral director, page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon paper(s). Page 1 and 2 should be detached for use at the burial-tranport permit. Then please remove carbon paper(s). Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical certification section must be completed.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 8 3 4 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>MABEL</b>	MIDDLE <b>RAE</b>	LAST <b>WHITMORE</b>	2a. DATE OF DEATH	MONTH <b>3/12/87</b>	DAY <b>12</b>	YEAR <b>1987</b>	2b. HOUR <b>9:47A M</b>			
3. SEX			4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 18, 1897</b>			6. AGE (IN YEARS (LAST BIRTHDAY) YRS. <b>89</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Walkersville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>24 Georgetown Rd./21793</b>	
14. FATHER'S NAME FIRST <b>A.</b>			MIDDLE <b>Scott</b>	LAST <b>Long</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b>Ellen</b>	LAST <b>Favorite</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-36-0218D</b>			17. INFORMANT ADDRESS <b>Mrs. Doris O. Alexander 24 Georgetown Road Walkersville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			respiratory insufficiency									APPROXIMATE TIME/MAY BETWEEN ONE CAUSE AND	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) severe congestive heart failure										
			(c) mitral stenosis + myocardial infarction										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that in (this hospital) attended the deceased from <b>2/21</b> , 19 <b>87</b> , to <b>3/12</b> , 19 <b>87</b> , that in (we) last saw the deceased alive on <b>2/22</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John Vitarello MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/12/1987</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Vitarello MD</b>			22e. ADDRESS <b>35 Park Avenue Frederick, Maryland 21701</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/16/1987</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Creagerstown Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Creagerstown, Frederick, Md.</b>				
24. FUNERAL DIRECTOR <i>R.E. Dailey &amp; Son, Inc.</i>			25a. ADDRESS <b>1201 N. Market Street Frederick, Md. 21701</b>			25b. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>			25b. REGISTRAR'S SIGNATURE <i>Julia S. Johnson-Randall</i>				
BP _____													
DHMH - 16 60M 7/B4 (VRA 15, 4)													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 4 4													
1 - STATE REGISTRAR								2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED X 3-11- 1987				2b HOUR 6 a M											
1. DECEASED NAME (TYPE OR PRINT)		FIRST RICHARD		MIDDLE STOCKSDALE		LAST WILLHIDE		2c. DATE PRONOUNCED DEAD March 12, 1987				2d HOUR 12:30											
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1917 69		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.											
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Thurmont				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15 North Carroll Street				12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Gov't. Emp.				12b KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>		13e. STREET ADDRESS 15 N. Carroll St. / 21788															
14. FATHER'S NAME FIRST Willie		MIDDLE Aimerman		LAST Willhicle		15. MOTHER'S MAIDEN NAME FIRST Zula		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) W.W. II				16b. SOCIAL SECURITY NO. 217-01-5382		17. INFORMANT Mrs. Peggy A. White Emmitsburg, Md. 21727				ADDRESS P.O. BOX 405					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								YES <input type="checkbox"/> NO X											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry X, and in my opinion death resulted from: Natural causes X, Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER											
ACTUAL SIGNATURE <i>Robert J. Thomas</i>												DATE SIGNED 3/12/1987											
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.		ADDRESS 812 Toll House Ave. Fred. Md. 21701																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-1987		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery				23d. LOCATION CITY OR TOWN Thurmont		COUNTY Frederick, Md.		STATE											
24. FUNERAL DIRECTOR <i>Robert J. Dudley</i> R. E. DALEY & SON, P.A.		615 E. Main Street Thurmont, Md. 21788				25a. DATE REC'D. BY REGISTRAR MAR 21 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Lindner</i>															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 8 3 4 5				
FOR STATE REGISTRAR			2d DATE OF DEATH MONTH DAY YEAR 31 11 87							2b. HOUR 8 55 AM				
1. DECEASED NAME (TYPE OR PRINT) Halldan MIDDLE LAST Zimmerman			5. DATE OF BIRTH MONTH Aug. 6, 1908 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 78			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
2. SEX Male			4. RACE White			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.		
10. CITY OR TOWN OF DEATH Mt. Airy			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasantview Nursing Home			12a. USUAL OCCUPATION Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming					
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Jefferson			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3723 Jefferson Pike, 21755		
14. FATHER'S NAME FIRST Charles MIDDLE Joseph LAST Zimmerman			15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE Mae LAST Stang											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-36-6659			17. INFORMANT Maurice C. Zimmerman, Middletown, Md. 21769			ADDRESS 7808 Pincic Woods Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) coronary arteriosclerosis										yrs				
DUE TO, OR AS A CONSEQUENCE OF (c) general arteriosclerosis										yrs				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Mr. Henry : Cardiomyopathy														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (in this hospital) attended the deceased from 1/14/87 to 3/11/87, saw the deceased alive on 3/15/1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not view the body after death.)										22c. DATE SIGNED 3/12/87				
22b. SIGNATURE <i>William Kardon MD</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Molton Kardon MD			22e. ADDRESS 2600 Century Plaza Columbia, Md. 21044											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 13, 1987			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Lutheran			23d. LOCATION Jefferson, Frederick, Maryland					
24. FUNERAL DIRECTOR, AGENT, OR ATTENDING PHYSICIAN North, Keeney and Basford Funeral Home ADDRESS 106 East Church Street, Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR MAR 24 1987			25b. REGISTRAR'S SIGNATURE <i>Julie Jackson Redden</i>								

